Health Insurance Coverage in South Dakota

Final Report of the State Planning Grant Program

Report to:

U.S. Department of Health and Human Services
Secretary Tommy G. Thompson

Prepared by:

South Dakota Department of Health
The Lewin Group

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For questions about the South Dakota State Planning Grant Program, please contact Bernie Osberg (Bernie.Osberg@state.sd.us) or Kenny Doppenberg (Kenneth.Doppenberg@state.sd.us), Department of Health, 600 East Capital Avenue, Pierre, SD 57501 or telephone 605 773-3364.

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EXECUTIVE SUMMARY

South Dakota was one of nine states in 2001 to be awarded one-year Health Resources and Services Administration (HRSA) grants to develop plans for expanding access to affordable health coverage to all state residents. Under the HRSA State Planning Grant (SPG) program, states were provided resources to conduct surveys and studies of their uninsured population and to design effective approaches for providing all citizens of the state with high-quality, affordable health coverage.

The State Planning Grant Program in South Dakota was launched early in the Summer of 2001, although state staff had been preparing for the grant during the previous year. The Department of Health, the lead administrative agency for the SPG, convened an Interagency Work Group of state officials who were charged with monitoring progress of the project and providing technical input to all major decisions concerning the grant. Members of the Work Group included staff from the South Dakota Department of Health, the Department of Social Services, the Department of Human Services, and the Department of Commerce and Regulation.

The State contracted with The Lewin Group of Falls Church, Virginia, to (1) collect and analyze information about the uninsured and underinsured in South Dakota; (2) survey employers in the state about health insurance benefits they offer to employees and dependents, and analyze resulting data; (3) develop options to increase health insurance for uninsured persons in South Dakota and estimate resulting program costs; and (4) draft a final report to HRSA.

A telephone survey was designed and completed of 1,502 households in South Dakota with at least one member who was uninsured in the Fall of 2001. The survey was designed to develop a broad understanding of uninsured persons' demographic and employment characteristics; to identify the reasons uninsured persons do not have coverage; and revealed the consequences of no health insurance. The survey was also intended to capture information (via an abbreviated questionnaire) about an additional 18,805 individuals who *do have* health insurance. This information was used for state program purposes (e.g. determine extent of prescription drug coverage among the insured population), and to derive more precise estimates of the number of persons who are uninsured.

The household survey provided detailed information that was analyzed in several steps. First, data (from insured and uninsured individuals) were used to refine Bureau of the Census' Current Population Survey (CPS) estimates for South Dakota and produce county-level estimates of the rate of uninsurance. These improved estimates are different from other published CPS estimates for South Dakota, which are often unadjusted and based on small sample sizes. As a result of careful refinements to the CPS, the estimated percent of uninsured South Dakotans dropped from 11.8 percent to 8.1 percent. Another key finding is that over 84 percent of the uninsured in the state are working men and women or their dependent children and spouses. The age groups most likely to be without insurance are young adults and those between 55-64 years of age.

Key highlights of the survey of the uninsured include:

- More than one-quarter of uninsured persons in South Dakota had no health insurance for one year or less. About 42 percent of the uninsured, however, were without coverage for five years or more.
- The primary reason the uninsured have no health coverage is because they cannot afford the monthly premiums; 80 percent of those surveyed report high premium costs as a major impediment to securing coverage.
- For over half of the uninsured in the state, health coverage is not available to them through their employment.
- One-quarter of the uninsured report they are either in fair or poor health, a rate nearly double that for South Dakotans as a whole.
- Nearly one-third of the uninsured in South Dakota report that they needed to see a doctor in the past 12 months, but didn't go because of cost concerns.
- Almost two-thirds of uninsured South Dakotans in poor health report having difficulty getting medical care when they need it, compared to nine percent of the uninsured in excellent health.
- The estimated rates of uninsurance vary by geographic region. The lowest rates of uninsurance were in the southeast region of South Dakota; the highest rates were in the south central and northwest regions of the state.

Results of the survey appear in Section I of this report.

A survey of employers was designed and carried out, also in the Fall of 2001, to identify the reasons that some employers offer coverage, while others do not, and the challenges that employers face in doing so.

Major findings of the employer survey include:

- About 55 percent of private employers in South Dakota offer health insurance to their employees.
- The major reason employers say they offer health insurance is to attract or retain workers.
- On average, 81 percent of the worker's insurance premium, and 39 percent of his/her dependent premium, is paid by employers in South Dakota.
- About 21 percent of surveyed employers in the state are self-insured, translating into approximately 62 percent of the workforce.
- The major reasons employers in the state report they do not offer health insurance is that coverage is too expensive for the company to afford and that their employees are covered elsewhere.
- There is geographic variation that employers recognize in the adverse effects of not providing health insurance to their workers. About 20 percent of non-insuring employers in the Pierre/Mobridge/Rapid City region report their uninsured employees are unable to obtain medical care, compared to seven percent in the Sioux Falls area.

- Nearly 60 percent of non-insuring firms in South Dakota say they would be interested in participating in a health insurance program that was subsidized by the state or federal governments.

Results of the employer survey are presented in Section II.

A series of eight focus group sessions were organized and sponsored in South Dakota during September and October 2001. Focus groups captured information about specific groups of uninsured and underinsured persons including those who are low-income, the self-employed, those who work for or own small businesses, Native Americans (living on and off-reservation), older and elderly persons, and farmers and ranchers. The purpose of the focus groups was to develop an understanding of the reasons why individuals are without health coverage, their attitudes about health insurance, and the kinds of initiatives that could be effective in enabling these individuals to obtain coverage. A summary of South Dakota's focus group findings appears in ***Appendix D***.

Key themes that emerge from the focus groups include:

- Focus group members' personal stories provided compelling evidence of the serious problems many South Dakotans face in trying to secure affordable and adequate health insurance. These problems seemed most widespread among lower income individuals, those with catastrophic or chronic medical conditions, and for individuals 50-64 years of age.
- Those who were farmers and ranchers, self-employed, or employed by small firms that don't offer job-based benefits reported extensive frustrations in their attempts to secure adequate and affordable coverage. Their low wages, modest monthly incomes relative to high premium costs and other household expenses, and/or the cyclical nature of their household incomes also undermined their ability to secure ongoing health coverage.
- The high cost of health insurance is the major factor influencing individuals and small employers' decisions not to purchase coverage for themselves, families, or workers. The high cost of health insurance is also the major reason that many individuals chose health policies with extremely high deductibles ($5,000) or limited benefits. Many focus group members perceive that insurance companies are "ripping them off" as evidenced by the extensive reporting of significant premium price increases for 2002; having their coverage dropped for reasons that seem beyond their control; and experiencing unexpected limits in benefits or payment amounts when medical claims are processed.
- In light of the difficulties individuals and families experience paying monthly premiums, there was a widespread belief expressed in many of the focus groups that health insurance isn't "worth it" if you don't use it (that is, seek medical care). At the same time, some focus group participants feared they could "lose everything" should medical catastrophe strike.
- Some focus group members wondered whether having health insurance would actually make life any easier for them to secure needed medical care, given health care shortages in many areas of the state.

- The Children's Health Insurance Program was almost universally hailed as a "good" and valuable state program by focus group members.

In addition to focus groups, structured in-person and telephone interviews were carried out with several health care provider and insurance groups and other key stakeholders in the state (such as consumers and businesses). From these interviews, project staff learned more about different organizational perspectives about the problem of health insurance in South Dakota and possible strategies for addressing it.

Each of these approaches was designed to elicit different kinds of information and to complement the other approaches. By triangulating information from the various sources, the scope and context of uninsurance in South Dakota was defined. Once data were tabulated, analyzed, and interpreted, the development of coverage options uniquely suited to South Dakota was initiated. Preliminary policy options to increase affordable health insurance coverage were developed by The Lewin Group, then discussed and evaluated by the Interagency Work Group. Based on the Work Group's assessment of several issues, including the feasibility of proposed approaches, policy options were refined and revised. For each option, Lewin estimated the number of persons who would become insured and the cost of adopting each option. The six policy options that were analyzed include:

- Expand income eligibility levels for adults under Medicaid and the State Children's Health Insurance Program (SCHIP);
- Create a Medicaid buy-in program for small employers and low-income persons;
- Create a private health insurance premium subsidy program for low-income persons;
- Create a private health insurance premium voucher program for small employers;
- Create a low-cost coverage option for small employers; and
- Expand direct services for uninsured older adults.

These options are presented in detail in Section IV of this report.

As the State of South Dakota considers options to expand affordable health insurance coverage, the Interagency Work Group recognizes the importance of federal action to support state efforts to provide coverage for the uninsured. Federal action is recommended in at least four areas:

1. The federal government should offer federal tax credits for purchasing health insurance coverage. This action is particularly important for South Dakota where there is no state individual or corporate tax.

2. State health care access initiatives often raise ERISA pre-emption concerns. The federal pre-emption for self-funded health plans should be removed to facilitate effective reform in the health insurance market and incorporate all players in state reform efforts.

3. There are nearly 63,000 American Indians living in South Dakota (8.3 percent of the state's population), according to the U.S. Census Bureau. The federal government should dramatically increase funding for the Indian Health Service, ease and revise IHS

requirements for contract health services, and use federal funds to facilitate Medicaid or alternative private coverage among American Indians. From a consumers' perspective, the burden that American Indians face in attempting to secure needed health coverage and medical services (both on- and off-reservation) undermines public efforts to improve the health status of *all* South Dakotans in measurable ways.

4. The federal government should address the deteriorating situation of health care access in frontier areas of the United States. It should identify effective frontier practice models and partner with states and tribal organizations to address the diminished availability of a wide range of health services in many areas.

As the South Dakota planning process continues even after this SPG phase is completed, there is much to be accomplished in the state. Many of the coverage expansions that have been considered would require action on the part of the State Legislature and developing a consensus around these issues will take some time. In addition, the State's fiscal situation will need time to improve sufficiently so that possible additional coverage programs can be considered.

SECTION I: THE UNINSURED IN SOUTH DAKOTA

The purpose of the South Dakota State Planning Grant (SPG) was to identify policies that will help bring affordable coverage to South Dakota residents who do not currently have health insurance. Before developing policy options, research was needed to help policymakers and the public better understand who the uninsured are in South Dakota and the reasons why many individuals and families are without coverage. Research was also needed to learn, from the perspective of uninsured individuals themselves, what private and public sector barriers to full health coverage exist in the state and what the consequences of these barriers are for individuals and families. This knowledge forms a basis for designing effective strategies to expand insurance coverage in South Dakota. A final step in the SPG effort was to estimate the costs and benefits of covering uninsured persons in the state. As some costs of program expansion may be borne by participants themselves, it is important to understand individuals' price sensitivity and preferences for program development.

To achieve South Dakota's objective of developing a better understanding of the state's uninsured population, a number of activities were undertaken. The project's consultant, The Lewin Group, developed baseline information from several years of national Current Population Survey (CPS) data. The data were then adjusted to yield more precise estimates of the number of uninsured. The effect of these adjustments was to reduce the estimated percent of uninsured persons from 11.8 percent (the figure often published) to 8.1 percent in South Dakota. Additionally, two-thirds of all uninsured persons in the state are working men and women. Over 50 percent of the uninsured have family incomes less than 200 percent of the federal poverty level ($14,630 for a family of three in 2001[1]). The results of Lewin's CPS analysis appear in ***Appendix A***.

Next, a telephone survey was completed of over 20,000 households in South Dakota to obtain a sample size of 1,500+ households having at least one member who is uninsured. New and detailed information was generated from this survey. Abbreviated interviews were also conducted with insured persons ("screen-outs"[2]), in order to provide the state with useful information about the coverage of the insured and their satisfaction with it. A series of focus group sessions was also conducted with a broad range of uninsured persons throughout the state. This multi-fold data collection effort led to a comprehensive understanding of the uninsured population in South Dakota in 2001.

A. Survey of the Uninsured

While the CPS data provides some quantitative demographic information, it does not answer questions pertaining to many characteristics of the uninsured such as, why and how long individuals are uninsured, or the health and financial consequences of living without insurance. To help answer these and other questions, a statewide telephone survey was conducted near the end of 2001. The survey was designed by The Lewin Group and the South Dakota Interagency Work Group. It was carried out by Baselice & Associates, Inc. of Austin, Texas. The sampling

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1 *Federal Register*, Vol. 66, No. 33, February 15, 2001, ppd. 10695-10697.

2 Persons who weren't eligible for the full survey because they had health insurance.

frame was designed to achieve broad representation of all areas of the state, particularly rural regions with small populations. The survey included complete responses from 1,502 uninsured individuals and data from a mini-survey of 18,805 insured individuals in South Dakota. The methods and approach used for the survey and focus groups can be found in ***Appendix B***. ***Appendix C*** includes all survey questions.

Highlights of the South Dakota Survey of the Uninsured are featured below.

1. Comparison of Uninsured to Insure Respondents

The uninsured and the insured groups differed from each other in a number of ways. ***Figure 1*** highlights these fundamental differences. As would be expected, persons who were uninsured were younger than those who were insured and fewer of them were married. The mean age of the uninsured was 42 while the mean age of the insured group was 51 years. Additionally, 44.3 percent of the uninsured group and 66.6 percent of the insured group was married. Approximately 25 percent of uninsured respondents were between 18 and 29 compared to 11.6 percent of the insured. Nearly half of the insured group was 50 years of age or more.[3]

Figure 1
Demographic Characteristics of Respondents

	Uninsured	Insured
Mean Age	42	51
Median Age	42	48
Age 18-29 years	25.0%	11.6%
Age 50+years	30.5%	47.8%
Married	44.3%	66.6%
Mean Number of Children in Household [a/]	1.32	1.66
% Anglo/White	91.1%	94.3%
	n=1,502	*n=18,805*

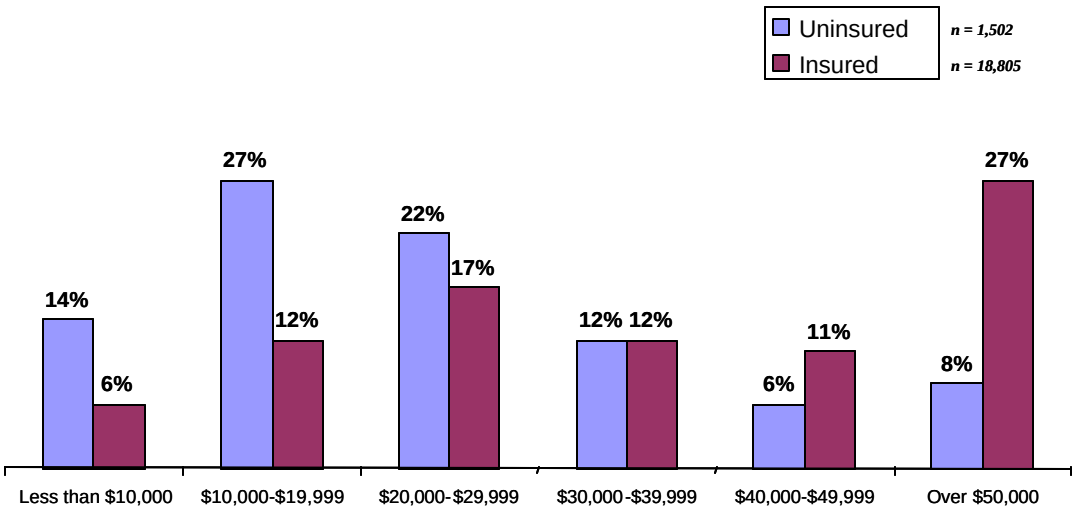
a/ Includes only households where children are present.

Source: Lewin Group Survey of the Uninsured in South Dakota, conducted by Baselice & Associates, Inc. (Fall 2001).

The telephone survey confirmed a hypothesized difference between the uninsured and insured groups in household income and insurance status. As seen in ***Figure 2,*** the percent of uninsured surpassed the insured group in the lower income categories (under $30,000). For example, 27 percent of the uninsured respondents had annual household incomes between $10,000 and $19,999 while only 12 percent of the insured were in that category. Similarly, eight percent of the uninsured had incomes over $50,000 compared to 27 percent of the insured. The majority of the uninsured (63 percent), had household incomes of less than $30,000 per year. Alternatively, 50 percent of the insured had household incomes of $30,000 or greater per year.

[3] It is likely that the high proportion of older insured respondents influenced the numeric values of the insured group presented in Figures 1-4.

Figure 2
Distribution of Uninsured and Insured Respondents by Household Income



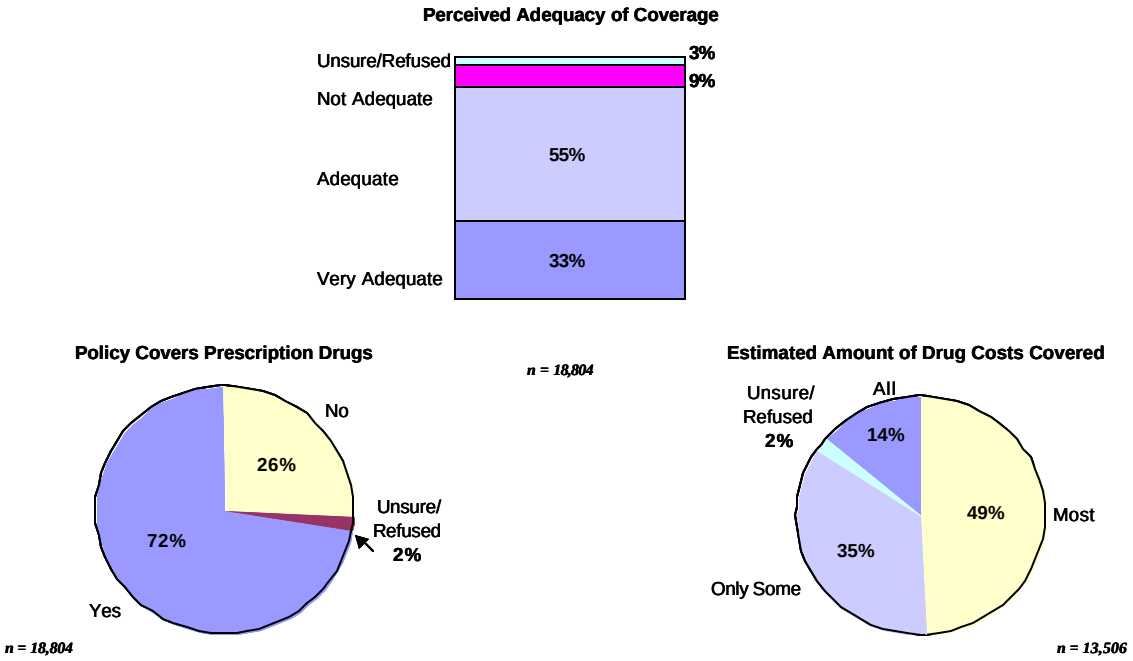
Source: Lewin Group Survey of the Uninsured in South Dakota, conducted by Baselice & Associates, Inc. (Fall 2001).

The South Dakota SPG project differs from other planning grant states in that Interagency Work Group staff used this unique survey opportunity to interview those *who do have* coverage in order to learn more about the insured population in the state.

Eighty-eight percent of insured persons described their health care coverage as "adequate" or "very adequate" while nine percent found it to be "not adequate." (Three percent refused or were unsure.) Nearly three-quarters of insured respondents (72 percent) reported they had a health plan that covered prescription drugs. Of those with prescription drug coverage, 14 percent reported that all of their drug costs were covered; 49 percent reported that most of the cost of drugs was covered; and 35 percent reported only some of the cost was covered. These findings appear in ***Figure 3.***

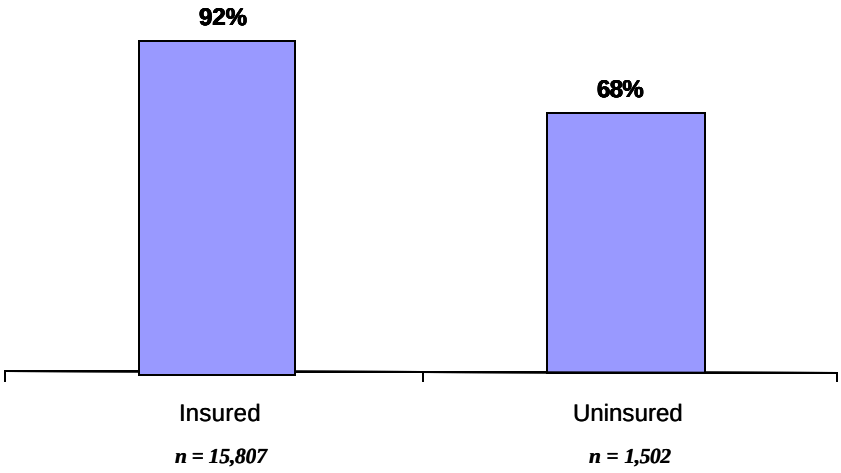
All insured and uninsured respondents were asked about how important having insurance coverage was to them. While 90 percent of the insured reported that having health coverage was very important to them, less than 70 percent of uninsured individuals reported feeling the same way. There remains much to learn about the behavior and insurance choices of the uninsured in this regard ***(Figure 4).***

Figure 3
Health Coverage for Insured Respondents



Source: Lewin Group Survey of the Uninsured in South Dakota, conducted by Baselice & Associates, Inc. (Fall 2001).

Figure 4
Percent Reporting that Having Insurance Coverage is Very Important



Source: Lewin Group Survey of the Uninsured in South Dakota, conducted by Baselice & Associates, Inc. (Fall 2001).

2. Characteristics of the Uninsured

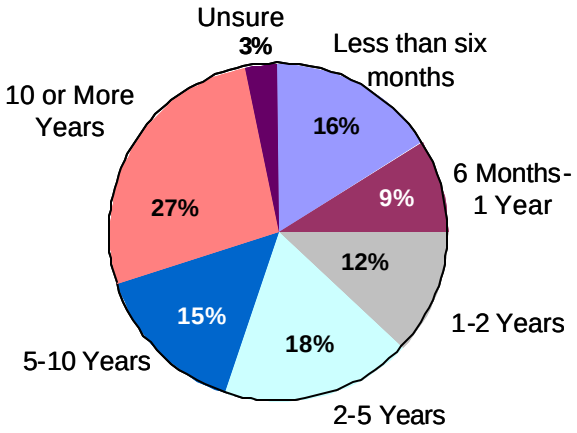
The telephone survey identified households in which there was at least one uninsured person. Nearly 80 percent of respondents were themselves uninsured. The remaining 21 percent reported on behalf of an uninsured spouse or other dependent in the household. The majority of respondents were female (56 percent). Respondents were primarily married (44 percent) or single (26 percent); the remainder were either divorced /widowed or living with a partner. Forty percent of respondents had children less than 18 years of age living in the household.

The survey revealed that forty-six percent of the uninsured had annual household incomes of under $20,000. Among uninsured households with wage earners, 45 percent reported that two or three wage earners lived in the household. Fourteen percent of primary wage earners in surveyed households were farmers or ranchers.

There was great variation in the length of time individuals reported they were without health coverage (***Figure 5)***. One quarter of the uninsured lacked coverage for one year or less. In contrast, 42 percent of the uninsured had no health insurance for five years or longer. Individuals uninsured for long periods of time are usually of greatest concern to policymakers.

Although many of the uninsured report that they are in good health ***(Figure 6)***, compared to the general population they are in worse health. Three-quarters of the uninsured assert they are in either excellent (29 percent) or good (46 percent) health. However, one-quarter are in either fair or poor health, a rate nearly double that for South Dakotans as a whole. The Centers for Disease Control's Behavioral Risk Factor Surveillance System (BRFSS) data indicated that 12.1 percent of South Dakotans viewed their general health as fair to poor in 2000.[4]

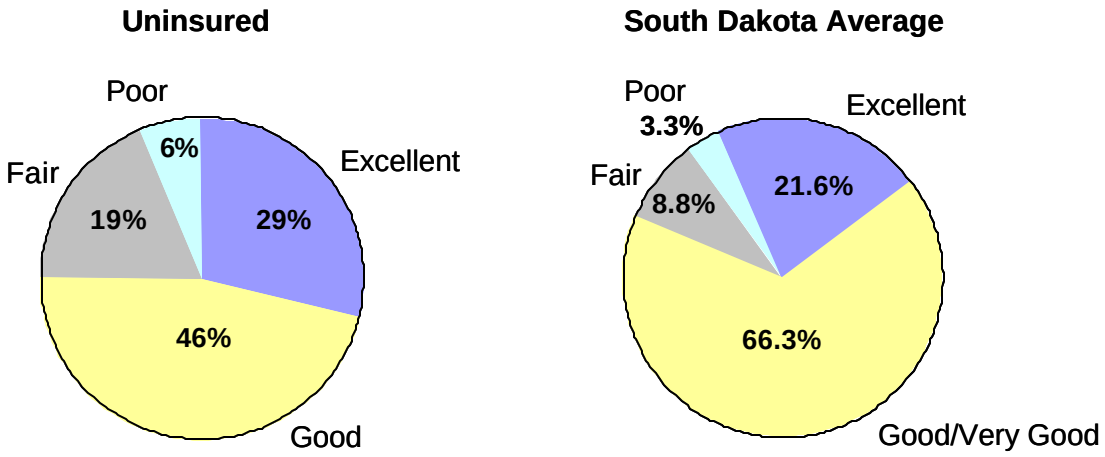
Figure 5
Length of Time Without Insurance



Source: Lewin Group Survey of the Uninsured in South Dakota, conducted by Baselice & Associates, Inc. (Fall 2001).

[4] Centers for Disease Control and Prevention (CDC). *Behavioral Risk Factor Surveillance System Survey Data.* Atlanta, Georgia: U.S/ Department of Health and Human Services, Centers for Disease Control and Prevention, 2000.

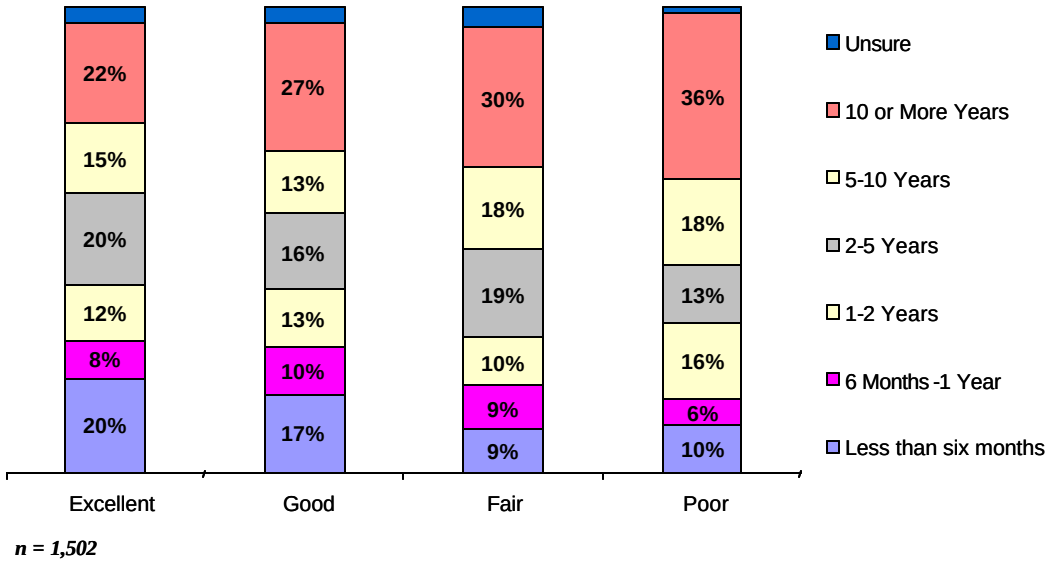
Figure 6
Self-reported Health Status of Uninsured and General Population



Source: Lewin Group Survey of the Uninsured in South Dakota, conducted by Baselice & Associates, Inc. (Fall 2001) and CDC's BRFSS data.

There is a relationship between the length of time South Dakotans are without insurance and their health status. Of those who report their health status is poor, 36 percent of them have been uninsured for ten or more years, while 16 percent have been uninsured for less than one year. Of those reporting their health to be excellent, 22 percent have been uninsured for at least ten years and 28 percent were uninsured for less than one year ***(Figure 7).*** These data indicate that lower health status is associated with longer periods of uninsurance.

Figure 7
Distribution of Length of Time Without Insurance and Self Reported Health Status

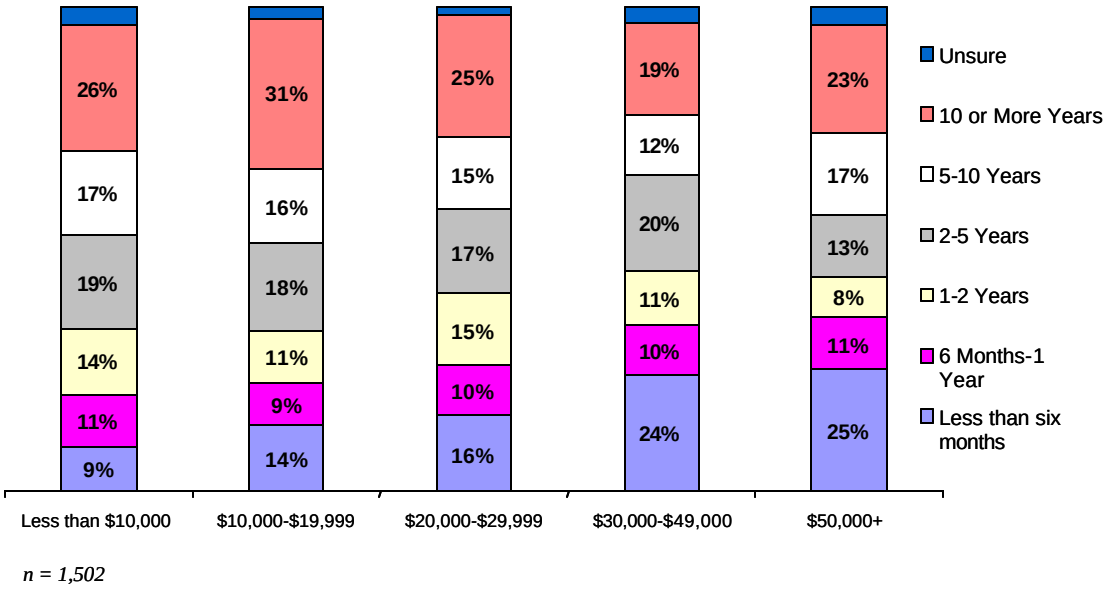


n = 1,502

Source: Lewin Group Survey of the Uninsured in South Dakota, conducted by Baselice & Associates, Inc. (Fall 2001).

An association between length of time without insurance and yearly income is evident. As seen in ***Figure 8***, 20 percent of those who earn less than $10,000 a year have been uninsured for one year or less, while 36 percent of those earning at least $50,000 have been uninsured for one year or less. These data indicate that for the uninsured, as household income increases, the probability of being uninsured for one year or less also increases.

Figure 8
Distribution by Length of Time Without Insurance and Household Income



n = 1,502

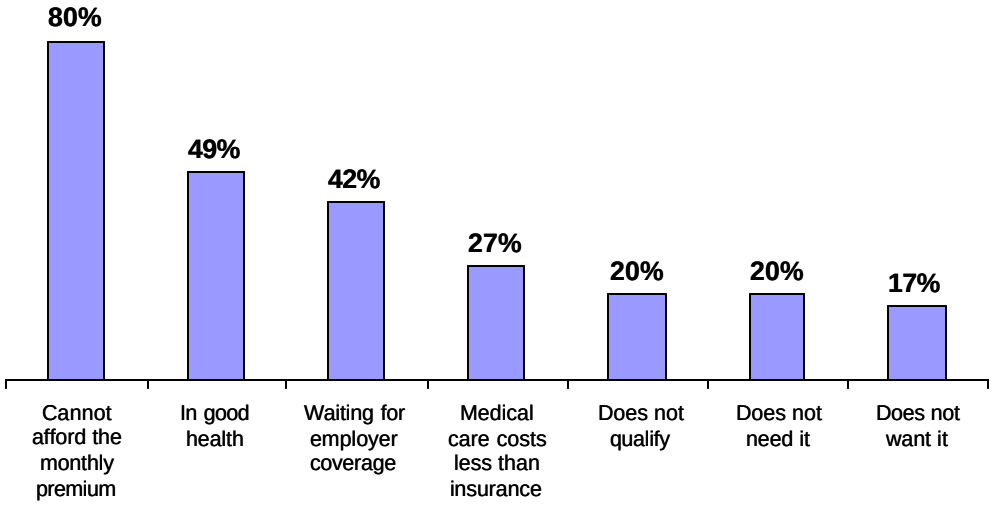
Source: Lewin Group Survey of the Uninsured in South Dakota, conducted by Baselice & Associates, Inc. (Fall 2001).

3. Reasons for Being Uninsured

The South Dakota survey provided a unique opportunity to ask uninsured persons the reasons they go without health coverage. The major reason the uninsured reported they have no coverage is that they cannot afford the monthly premium; 80 percent stated this was a key reason for not having health insurance ***(Figure 9)***. Forty-nine percent of the uninsured asserted they did not have coverage because they were in good health and 42 percent were waiting for employer coverage. Another major reason the uninsured said they do not have health insurance was that the medical care they needed costs less than health insurance.

Having health insurance in South Dakota is closely linked to employment, as elsewhere in the United States. Employment, however does not automatically guarantee the opportunity for health coverage. As seen in ***Figure 10,*** nearly half (48 percent) of the uninsured are employed by others and 27 percent are self-employed. Only one quarter of the uninsured in this survey are unemployed or not currently working for pay.

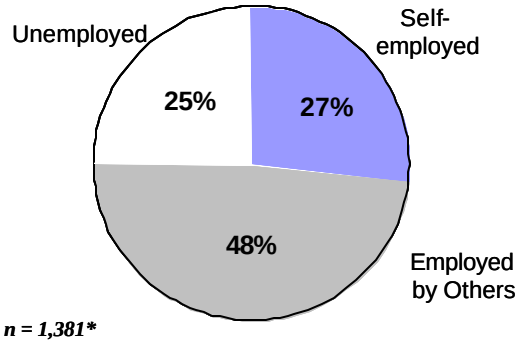
Figure 9
Primary Reasons for Not Having Health Insurance



n = 1,502

Source: Lewin Group survey of 1,502 uninsured persons in South Dakota, conducted by Baselice & Associates, Inc. (Fall 2001)

Figure 10
Uninsured by Employment Status



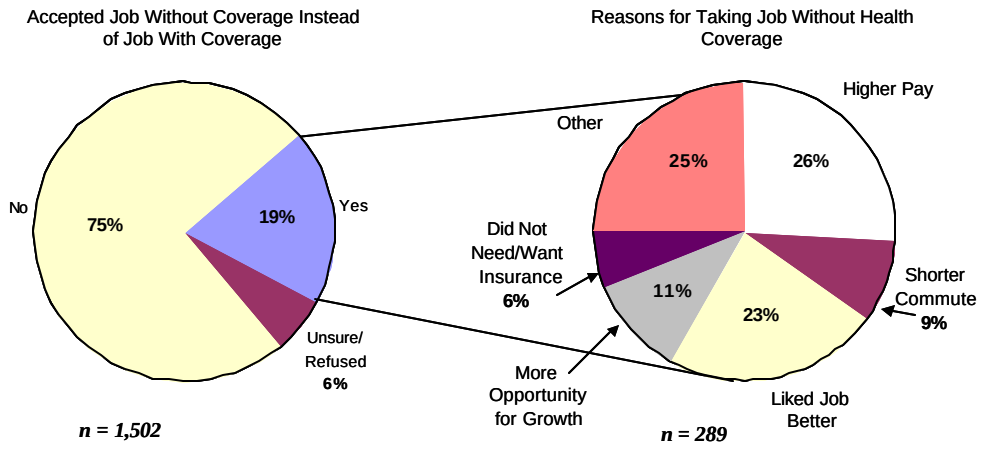
n = 1,381*

****This question was not asked of 121 respondents, as the uninsured person in the household was either a minor or an adult not in the workforce (e.g. parent)***

Source: Lewin Group Survey of the Uninsured in South Dakota, conducted by Baselice & Associates, Inc. (Fall 2001).

Three-quarters of the uninsured have never accepted a job without health coverage instead of a job with coverage ***(Figure 11).*** Nineteen percent of respondents reported accepting a job without coverage instead of a job with coverage. The primary reasons they did so was higher pay (26 percent) and the fact that they liked the job better, despite it not offering health insurance coverage (23 percent).

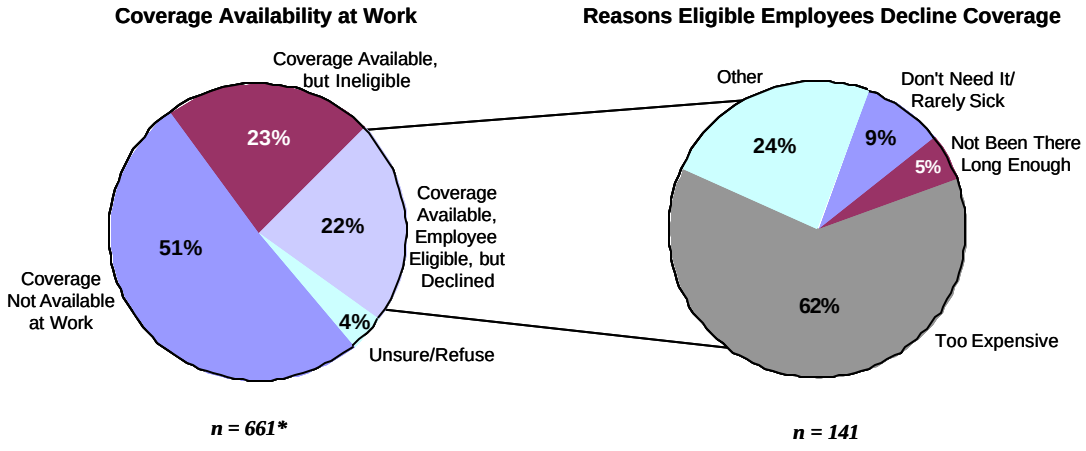
Figure 11
Accepting Employment Without Health Benefits



Source: Lewin Group Survey of the Uninsured in South Dakota, conducted by Baselice & Associates, Inc. (Fall 2001).

The survey revealed that for over half of the uninsured in South Dakota, health coverage is not available to them through their employment. Another 23 percent are ineligible for the job-based coverage that is available to them. Not all individuals who are offered employer-based coverage accept this benefit ***(Figure 12).*** About 22 percent of the state's uninsured report they have coverage available to them through employment, but they do not accept this benefit. Most (62 percent) of them decline this coverage because it is too expensive.

Figure 12
Eligible at Work but Declined Coverage

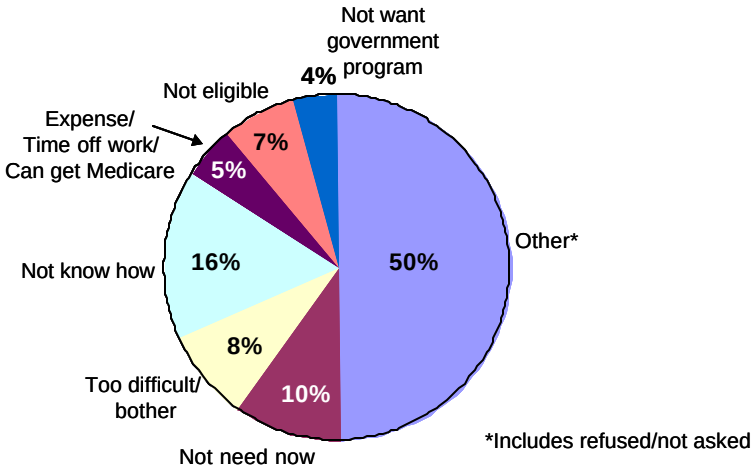


Only respondents who work for someone else were asked this question.

Source: Lewin Group Survey of the Uninsured in South Dakota, conducted by Baselice & Associates, Inc. (Fall 2001).

Because of the relatively low income of many of the uninsured, it was hypothesized that a large percentage of them may be eligible for state health insurance programs, such as Medicaid or the Children's Health Insurance Program (SCHIP). Fifty-seven percent of the uninsured did not think that they, or others in their families, would be eligible for such assistance. Another 26 percent were unsure. However, 16 percent of the uninsured believed that they (or another family member) might be eligible for Medicaid or SCHIP but they had not applied for assistance. They did not apply for this assistance for many reasons ***(Figure 13).***

Figure 13
Reasons for Not Applying for State Programs Among Those Who Think They Are Eligible



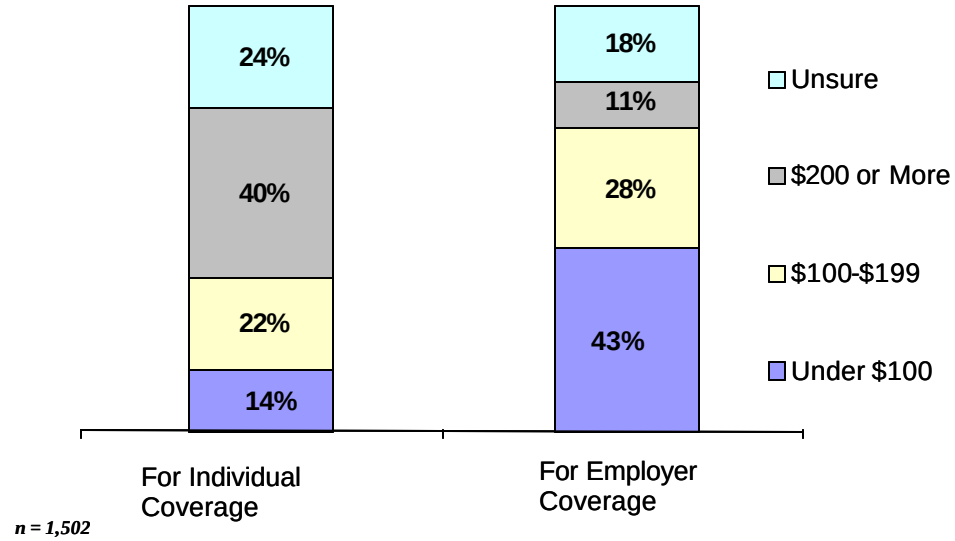
n=239

Source: Lewin Group Survey of the Uninsured in South Dakota, conducted by Baselice & Associates, Inc. (Fall 2001).

Respondents in households either with children or who were not covered by Medicaid or SCHIP were asked whether they had ever applied for program. Forty-two percent of these respondents (*n*=595) reported they had applied at one time or another for Medicaid or SCHIP. Of these cases, one-third of them had one or more children currently enrolled in Medicaid or SCHIP

Although research continues to confirm that high cost is the primary deterrent to attaining health insurance, many uninsured respondents did not know how much health coverage might cost. For example, 24 percent of the uninsured were unsure what the out-of-pocket cost of coverage would be for individually purchased coverage ***(Figure 14).*** Forty percent believed *individual* coverage would cost $200 or more per month. Similarly, 18 percent of uninsured respondents were unsure how much *employer* coverage would cost them. Respondents recognized, however, that employer coverage would be significantly less expensive: 43 percent of the uninsured thought employer coverage would cost under $100 compared to 14 percent if purchased as an individual policy. This finding, in combination with the survey result that over 75 percent of workers in South Dakota have never accepted a job without coverage, indicates that most workers want their employers to continue playing a role in providing health insurance.

Figure 14
Perceived Monthly Out-of-Pocket Cost of Employer and Individual Coverage



Source: Lewin Group Survey of the Uninsured in South Dakota, conducted by Baselice & Associates, Inc. (Fall 2001).

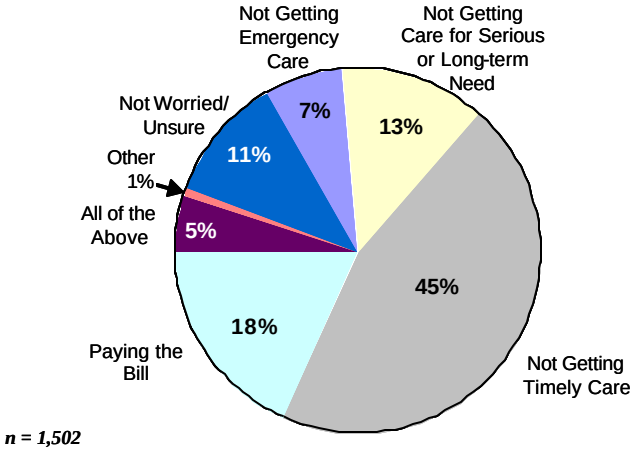
4. Consequences of Being Uninsured

The telephone survey offered the opportunity to investigate the consequences individuals experience as a result of not having health coverage and the related issues that primarily trouble them. The main worries of the uninsured population in South Dakota concern the health and financial consequences of being without health insurance ***(Figure 15)***. The *major* worry of uninsured South Dakotans is access to timely medical care (45 percent). Another 13 percent worry about getting care for serious or long-term medical needs, and seven percent primarily worry about not getting emergency care when needed. In combination, 65 percent of the uninsured in South Dakota primarily worry about access to various kinds of medical care as a result of not having coverage. Less than 20 percent (18 percent) of the uninsured report their biggest worry is the inability to pay a medical bill after receiving care.

The health and financial consequences of not having health coverage can be significant. Nearly one-third (32 percent) of the uninsured in South Dakota needed a doctor in the past 12 months but did not go due to cost. The percent of uninsured who delay seeking medical care is much higher than for the general state population, as a whole. BRFSS data for South Dakota indicates that only 7.2 percent of the population delayed seeing a doctor because of cost in 1999.[5]

[5] Centers for Disease Control and Prevention, *op.cit.*

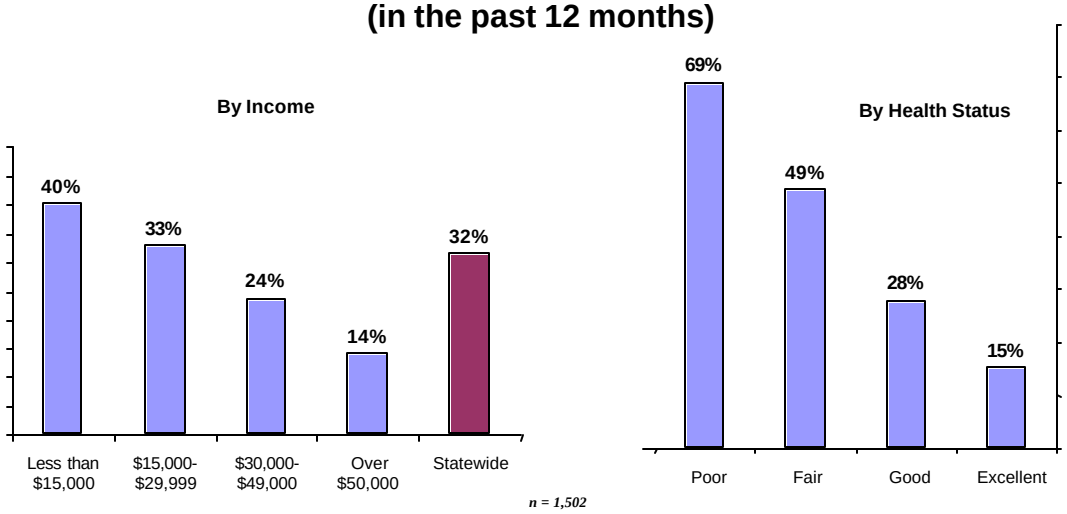
Figure 15
Main Worry About Being Uninsured



Source: Lewin Group Survey of the Uninsured in South Dakota, conducted by Baselice & Associates, Inc. (Fall 2001).

Looking at South Dakota's uninsured population by income and health status further reveals the implications for those without insurance. Forty percent of the uninsured earning less than $15,000 per year reported needing a doctor in the past 12 months but not going due to cost. For those earning over $50,000, only 14 percent of the uninsured experienced such a situation. This finding suggests that uninsured individuals with higher incomes have access to care when they need it ***(Figure 16).*** For those in poor health, however, uninsurance is a serious deterrent to prompt medical care. Sixty-nine percent of those who reported being in poor health did not see a doctor when needed. This percentage dropped as reported health status improves. This suggests that uninsured persons with ongoing medical care needs frequently are unable to get care because of cost concerns.

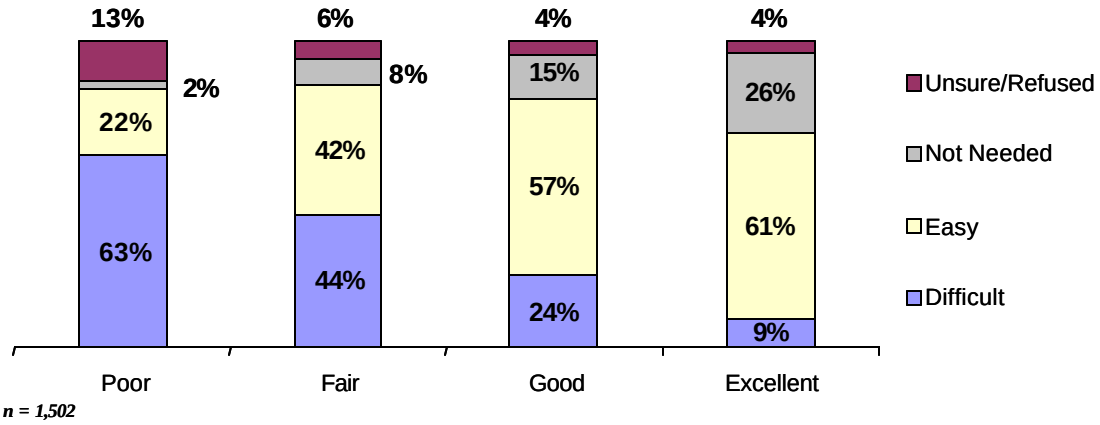
Figure 16
Needed a Doctor But Did Not Go Due To Cost
(in the past 12 months)



Source: Lewin Group Survey of the Uninsured in South Dakota, conducted by Baselice & Associates, Inc. (Fall 2001).

The ease with which the uninsured in South Dakota secure needed medical care varies widely by self-reported health status ***(Figure 17).*** Nearly two-thirds (63 percent) of uninsured persons in poor health report having difficulty getting medical care when they need it, compared to nine percent of those in excellent health. Alternatively, 22 percent of uninsured Dakotans in poor health find it easy to get medical care, compared to 61 percent of those in excellent health. In combination with the previous findings, one can conclude that the uninsured, particularly those in poor health, have a difficult time obtaining medical care and often delay getting treatment in South Dakota.

Figure 17
Difficulty in Getting Medical Care by Health Status

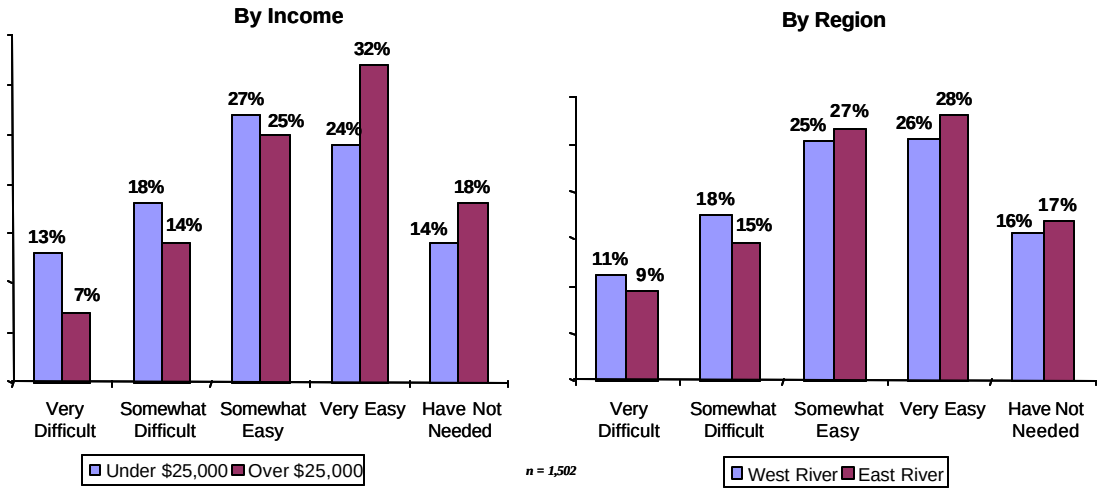


Source: Lewin Group Survey of the Uninsured in South Dakota, conducted by Baselice & Associates, Inc. (Fall 2001).

Exploring the difficulty in obtaining medical care by annual income and by geographic region offers further insight into the experience of the uninsured in ways similar to those who have not seen a doctor because of cost ***(Figure 18).*** Fewer lower income uninsured persons have not needed medical care since they were uninsured, as compared to those with higher incomes. While thirteen percent of those earning less than $25,000 per year find it very difficult, only seven percent of those earning over $50,000 find it very difficult to get needed medical care. Likewise, 24 percent of those with incomes less than $25,000 and 32 percent of those with incomes above $25,000 per year report that it is very easy to get medical care. Some regional differences are also apparent. The survey indicates that it is somewhat harder for the uninsured to get needed medical care in the western half than the eastern half of the state ***(Figure 18).***

As such a large percent of uninsured individuals assert that it is both hard to get care and that they delay getting care due to the cost, it is important to understand where they go for medical care. Over two-thirds (69 percent) of the uninsured in South Dakota go to the doctor's office for needed medical care. Twenty percent go to the hospital emergency room, and eight percent use the Indian Health Service or other health care providers such as community health centers.

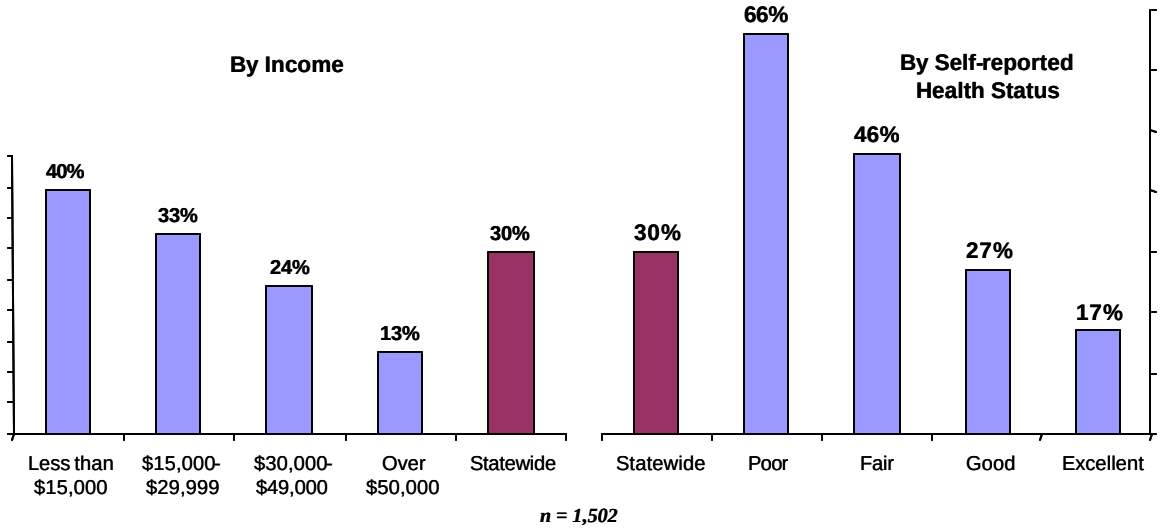
Figure 18
Difficulty in Getting Medical Care



Source: Lewin Group Survey of the Uninsured in South Dakota, conducted by Baselice & Associates, Inc. (Fall 2001).

The financial repercussions of being without coverage can be harsh, even though nearly thirty percent of the uninsured claim that medical care is less expensive than medical coverage (see page 8). Thirty percent of the uninsured report they have large bills that are difficult to pay ***(Figure 19).*** Uninsured persons with the lowest annual incomes and the poorest self-reported health status have the greatest difficulty paying large medical bills. Forty percent of the uninsured with yearly incomes of less than $15,000 have large medical bills and 66 percent of those with no coverage in poor health experience this financial distress.

Figure 19
Large Medical Bills That Are Difficult to Pay



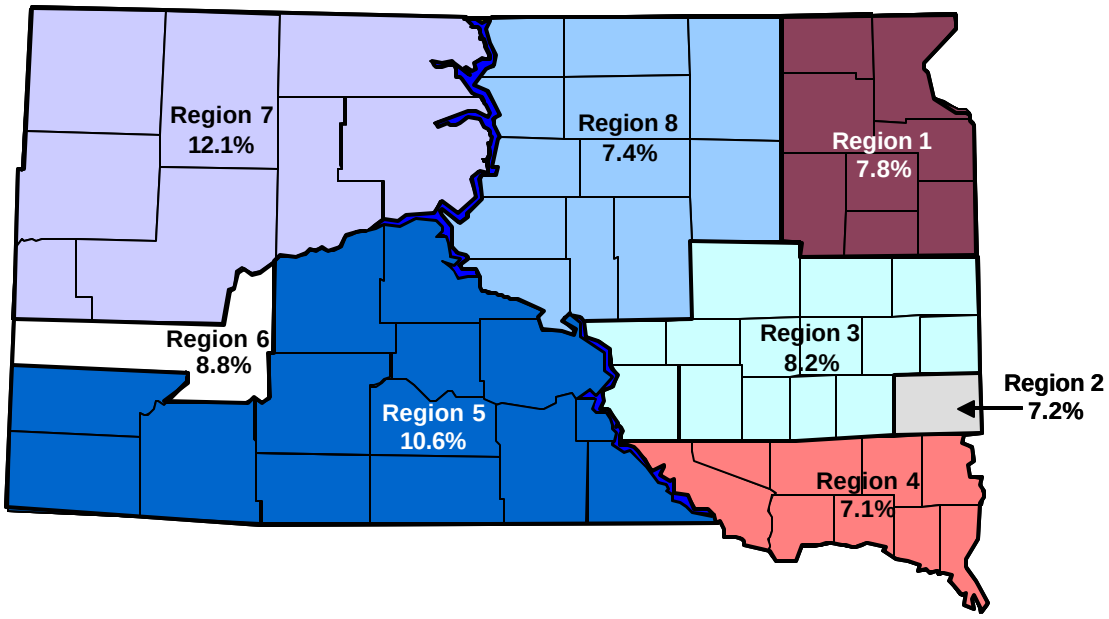
Source: Lewin Group Survey of the Uninsured in South Dakota, conducted by Baselice & Associates, Inc. (Fall 2001).

5. Geographic Variation in Uninsurance Rates

As described in ***Appendix A***, some household survey data were applied to Current Population Survey (CPS) estimates of the number of uninsured persons in South Dakota. These adjustments reduced to 8.1 percent the total estimated percent of uninsured South Dakotans.

The number of telephone calls was based on a representative sample of the state's population; total population estimates for each county (based on the 2000 Census) were grouped into eight geographic regions. The distribution of survey responses and adjustments (as described above) yielded regional variations in the rate of uninsurance across South Dakota. The lowest rates of uninsurance were in the southeast corner of the state. The highest rates were in the south central and northwest regions of South Dakota ***(Figure 20).***

Figure 20
Geographic Variation in Rates of Uninsured



Source: Lewin Group Survey of the Uninsured in South Dakota, conducted by Baselice & Associates, Inc. (Fall 2001).

6. Survey Summary

The findings described throughout this report yield new information about those with no health insurance in South Dakota, including their demographics, their worries, and the consequences they experience as a result of not having health coverage. The survey documented that the overwhelming majority of uninsured South Dakotans are workers who are either employed by others or self-employed. It demonstrated that uninsured persons in poor health or with limited incomes have particular difficulties accessing needed health care. These findings suggested which particular population groups are particularly important for South Dakota to consider in

developing targeted expansion options. They include uninsured workers and older adults (age 55-64) who are uninsured. Thus, it can be concluded that state surveys, such as described above, are important tools for policymakers as they develop options for making health insurance more available and affordable in their states. The survey also revealed important differences between the insured and the uninsured in their attitudes toward coverage.

B. Focus Groups of Uninsured Individuals

The South Dakota Survey of the Uninsured provided quantitative data on the scope of the uninsured problem in the state. The survey helped the SPG project team develop a deeper understanding of the barriers involved in the purchase of coverage as well as the consequences of being without coverage. In order to develop an even more meaningful understanding of the issues that confront uninsured individuals, The Lewin Group conducted focus group sessions with uninsured South Dakota residents. Compared to surveys, focus groups provide a deeper understanding of the scope and environmental context of the uninsured and underinsured population by probing individual attitudes, values, knowledge, and past experiences with respect to health insurance and health care. This consumers' point of view is important as it offers clues about how private and public programs could be modified to facilitate coverage and the incentives that could be designed to induce more individuals to secure health insurance. Such qualitative information must be considered prior to designing and assessing policy options to increase affordable health coverage to residents of the state.

Eight focus groups of 87 uninsured or underinsured individuals were sponsored in seven towns throughout South Dakota in September and October 2001. This distribution assured that researchers obtained a geographically representative sample of individual views, in both rural and urban areas, about the experience and consequences of being uninsured. Based on SPG Interagency Work Group staff preferences, some focus groups were designed to capture information about particular groups of uninsured persons, such as low-income or self-employed individuals, farmers, ranchers, Native Americans, and the elderly ***(Figure 21).*** The approach used to recruit focus group participants is described in ***Appendix B***.

Figure 21
Focus Group Location and Target Group

Date	Location	Participant Grouping
9/26/01	Sioux Falls	Lower Income Individuals
9/26/01	Sioux Falls	Small Business Employers
9/27/01	Yankton	Farmers/Ranchers
9/28/01	Winner	Farmers/Ranchers
9/29/01	Rapid City	Native Americans
10/1/01	Eagle Butte	Native Americans
10/2/01	Pierre	Older Americans
10/2/01	Aberdeen	Small Business Employers

Key findings that emerged from the focus groups expanded on the findings of the Survey of the Uninsured. While certain demographic groups were confirmed to comprise the bulk of the uninsured population, focus groups revealed that the uninsured range in age, socioeconomic wellbeing, and health status. Although focus group participants were varied in personal characteristics, most were in agreement regarding their fear and frustration over health insurance. Participants were generally uneasy if they were either uninsured or "under-insured". They reported widespread fear of being dropped by insurance carriers for reasons beyond their control. They also reported frustrations about the limited choices they had available to them with respect to insurance companies or plans that met their particular needs. Problems in securing affordable coverage were most severe among individuals in poorer health or lower economic status. The experiences that focus group members described were not new issues for them for being un- or under-insured was often a chronic situation.

In examining their personal stories, intricate problems surfaced that South Dakotans encounter when trying to secure affordable and adequate health insurance. Low wages and the cyclical nature of household income accentuated the challenge of securing affordable health coverage. The high cost of insurance was a primary deterrent to having health coverage. Many individuals conveyed their beliefs that the high cost of health insurance, often catastrophic in nature, is not worth the investment. These individuals, often younger and healthier, were willing to assume the risk of ill health and debt rather than invest in coverage. Focus groups throughout the state revealed a deeply rooted ethic of self-reliance, as well as great resourcefulness, in forging solutions to the problems that individuals experience in attempting to access needed medical care and prescription drugs. While many participants rejected the use of government aid, most agreed that the government should help monitor and control the cost of health insurance and make it possible for lower income individuals and families to afford health coverage. A full report of focus group findings is in ***Appendix D.***

C. Synthesis

All analyses conducted during the SPG project confirm that the greatest obstacle to acquiring health coverage in South Dakota is high cost. The cost of health insurance is perceived by both un- and under-insured as especially high given the relatively low wages in much of the state and the high proportion of small employers and individuals who are self employed. Whether workers and their families are unable to purchase employer-based coverage or an individual policy, high cost is consistently the main deterrent especially given their often modest or unpredictable incomes. Additionally, health insurance is often viewed as not being "worth it," considering how little some individuals use health care or how affordable essential medical care is perceived to be. In South Dakota, a largely frontier state, the issue of self-sufficiency arose frequently, especially given the difficulty of geographic access to medical care.

Both the survey and the focus groups revealed that the uninsured, especially low-wage earners, delay obtaining needed medical care. Survey respondents and focus group members consistently reported they defer meeting their medical needs due to the high cost of medical care. Of concern to public health officials, uninsured persons in poor health do not seem to be able to get the care they need in a timely fashion.

Differing perceptions among survey respondents and focus group members of "affordable" and "adequate" coverage are discussed in depth in Section Three of this report. Targeted market research would need to be conducted to learn more precisely about the uninsured's willingness to pay for coverage or their interest in securing a bare-bones benefit package. The survey and focus groups conducted for the SPG project provide limited indications of the amount of money that individuals would be willing to pay for basic coverage. Results of the survey indicate that 45 percent of the uninsured would be willing to pay up to $99/month for a plan that provides basic coverage for doctors visits, hospitalization, and prescription drugs. Another 27 percent were unsure of the amount, if any, that they would pay. Focus group members were also quite sensitive to price, depending on their family status, income level, and health care needs.

Findings from the survey and focus groups affirmed that many South Dakotans believe that government should be involved in helping uninsured individuals secure coverage, especially those considered "low income." Specifically, those queried think that government should be involved in the financing of this coverage for the uninsured or controlling the rapidly escalating cost of health coverage and medical care. This research suggests that uninsured individuals may be influenced by the availability of public subsidies, administrative simplification in the Medicaid program, insurance market reforms, or other approaches that would facilitate access to affordable coverage. While typically self-sufficient, many South Dakota residents firmly believe the health insurance situation is such that government's intervention is needed to help those who consistently find themselves unable to access affordable health coverage and medical care.

SECTION II: EMPLOYER-BASED COVERAGE IN SOUTH DAKOTA

The purpose of the South Dakota State Planning Grant (SPG) was to identify policy options that could help cover South Dakota residents and their families who do not currently have health insurance. Developing strategies to expand health coverage requires a multi-faceted approach to fully address the complexities of why people go uninsured. As employers provide the foundation of private health coverage in South Dakota and throughout the United States, an understanding of the health insurance benefits from their viewpoint is essential.

More than four-fifths of non-elderly uninsured Americans are in families with at least one adult worker[6]. With the erosion of employer-based coverage in some sectors, researchers are increasingly studying why and how working individuals go without coverage. At a time when unemployment is at a seven year low,[7] but with still many uninsured, Congress has been addressing employer-based coverage issues for the past few months as they debate economic stimulus measures and how to cover those who recently lost their jobs.

This national debate leads to the imminent need to understand, from the perspective of businesses themselves, the coverage employers are currently providing throughout South Dakota. It is important to learn what barriers prevent companies from providing health insurance to workers and their dependents; what companies report about why workers decline employer-based coverage; and what policy mechanisms might induce companies to provide health coverage in the future. This knowledge plays a key role in designing policy options and effective workplace strategies to expand health coverage in South Dakota.

As in the research conducted on uninsured persons in South Dakota, the telephone survey of private employers, focus group sessions, and structured interviews were all designed to provide a comprehensive picture and to complement each other in terms of the type of information generated. The survey provided quantitative information about employers in the state who both offer and do not offer health insurance to their workers. The objective of the survey was to gather information about employers' behavior with respect to their provision of health insurance, to track trends in health coverage provided by employers, and to assess selected policies designed to regulate or expand employer-based coverage for employees and their dependents. The focus groups and structured interviews provided qualitative data with an opportunity to explore and probe deeper into the attitudes of employers concerning their decision-making about offering health insurance. Furthermore, the focus group revealed the constraints that employers experience in doing so and the kinds of policy initiatives that employers believe would effectively enable more of them to offer health coverage.

The purpose of this section is to present quantitative and qualitative data on the status of employer-based coverage in South Dakota. A description of the survey's methods and approach is in ***Appendix E.*** Survey questions are listed in ***Appendix F.***

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[6] Jeanne M. Lambrew, *Health Insurance: A Family Affair*, New York: The Commonwealth Fund, May 2001.
[7] Bureau of Labor Statistics, U.S. Department of labor, January 2002.

A. Survey of Private Employers in South Dakota

As a second step in the SPG data collection process, a telephone survey of private employers in South Dakota was fielded in order to obtain some understanding of their decision to offer health insurance to employees and the kinds of coverage that are offered. Due to the breadth of the sample design, information on characteristics among firms offering and not offering health insurance to their employees can be compared. Researchers identified employers' perspectives about the reasons employees decline benefits, consequences to employees who do not receive the benefit, and potential ways of expanding coverage. Characteristics of the employers surveyed are summarized on the following pages.

The telephone survey was designed by The Lewin Group, in consultation with Baselice and Associates Inc., of Austin, Texas (who conducted the 20 minute telephone survey in September 2001) and the South Dakota Interagency Work Group staff. All private businesses in the state with two or more employees were included in the universe from which the sample was selected. The sample frame was intended to be broadly representative of all private businesses in South Dakota. Telephone surveys were completed in September 2001. A total of 401 usable surveys were generated. Of this total, 222 employers (55 percent) offered health insurance to their workers and 179 employers did not.

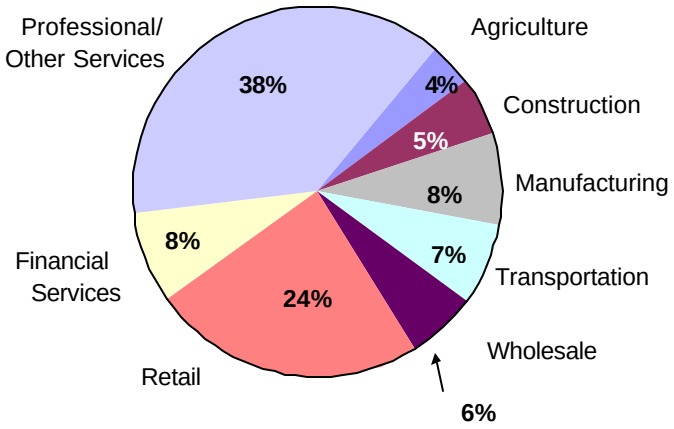
1. Characteristics of Responding Employers

Of the 401 firms surveyed, 38 percent were defined as professional and other services, the largest industry category ***(Figure 1)***. Retail employers comprised the second largest percentage of firms (24 percent). Firms providing financial services were eight percent of surveyed employers. The remaining 30 percent of employers surveyed included those in agriculture, construction, manufacturing, transportation, and wholesale industries.

Businesses in South Dakota are generally small. The average number of people employed by surveyed companies was thirty-one, while the median number of employees was five. An estimated 28 percent of businesses surveyed had two or three employees. Another 42 percent of the companies employed four to ten people. Only eight percent of firms were companies with over 50 employees ***(Figure 2).***

Businesses with employees at different wage levels participated in the survey. Forty-three percent of responding firms had at least one employee earning less than $10,000 per year and 62 percent of responding firms had at least one employee earning between $10,000 and $20,000. Ten percent of firms had at least one employee earning over $100,000 per year ***(Figure 3)***.

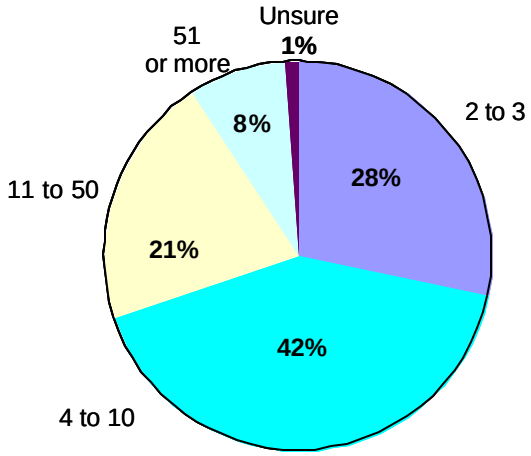
Figure 1
Employer Sample By Type of Industry



n = 401

Source: Lewin Group Survey of Employers in South Dakota, conducted by Baselice & Associates, Inc. (Fall 2001).

Figure 2
Surveyed Employer Characteristics by Firm Size



n = 401

Source: Lewin Group Survey of Employers in South Dakota, conducted by Baselice & Associates, Inc. (Fall 2001).

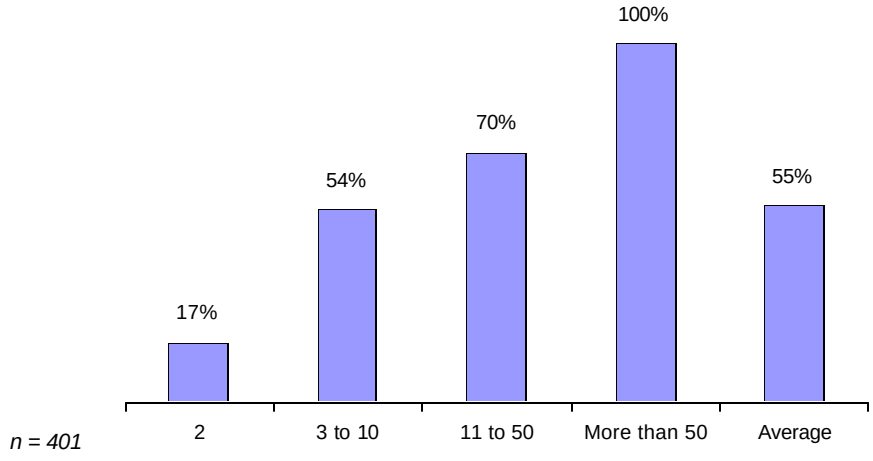
Figure 3
Wage Level of Surveyed Employers

Source: Lewin Group Survey of Employers in South Dakota, conducted by Baselice & Associates, Inc. (Fall 2001).

2. Characteristics of Insuring Firms

Survey results indicate that 55 percent of private employers in South Dakota offer health insurance to their employees. Six percent of surveyed firms offer insurance to company retirees. The percentage of firms offering health insurance, however, varies according to firm size and geographic location. While all (100 percent) firms with over 50 employees offer insurance to their full-time employees, about half of the firms (54 percent) with three to ten employees report offering health insurance and only 17 percent of firms with two employees offer insurance. As in other parts of the United States, the likelihood of offering health insurance in South Dakota varies greatly by firm size.

Figure 4
Percent of South Dakota Employers that Offer Health Insurance by Size of Firm

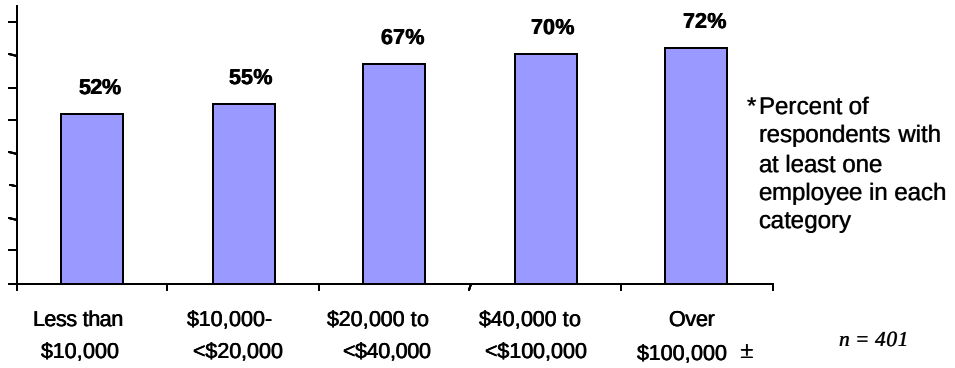


Source: Lewin Group Survey of Employers in South Dakota, conducted by Baselice & Associates, Inc. (Fall 2001).

Among different geographic regions of the state, the percent of firms offering insurance varied by nearly 20 percentage points. In the Pierre/Mobridge/Rapid City region, 44 percent of employers offered insurance while 63 percent of firms offered it in the Sioux Falls area. In the Watertown/Mitchell/Aberdeen region, 57 percent of firms offer health insurance. This spread indicates that rural location, and the type and size of businesses that serve the geographic region, diminishes the likelihood that health insurance will be offered to employees. The size of firms (in terms of employees) offering health coverage varied by geographic region as well. The average size of firms in Watertown/Mitchell/Aberdeen is 27 employers; in Sioux Falls, it is 42; and in Pierre/Mobridge/Rapid City, it is 107 employees.

As shown in ***Figure 5***, the percent of employers offering health insurance also increases as wage levels increase. Slightly more than half of South Dakota firms with employees in lower wage categories (less than $20,000 annual income) offer health insurance to their employees while 72 percent of firms with at least one employee earning over $100,000 offer health coverage.

Figure 5
Percent of South Dakota Employers that Offer Health Insurance By Wage Level*



Source: Lewin Group Survey of Employers in South Dakota, conducted by Baselice & Associates, Inc. (Fall 2001).

Coverage also varies with sales volume. The percentage of companies in South Dakota offering health benefits increases significantly as sales volume increases.

- Less than $500,000 (30 percent of employers)
- $500,000 to $2.5 million (63 percent of employers)
- $2.5 million or over (89 percent of employers)

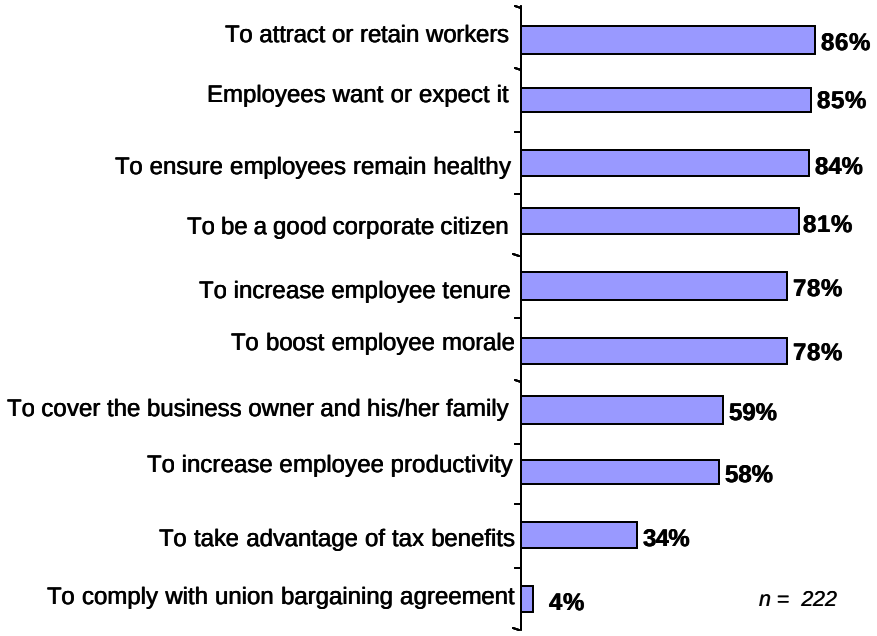
When the majority of employees are college graduates or skilled laborers, 62 percent of private employers in South Dakota offer health benefits. The percentage of employers offering health benefits drops to 52 percent for those with primarily manual laborers and 45 percent for those with primarily clerical or service workers.

The probability of offering health insurance also varies by industry type. Employers classified as agricultural (73 percent), manufacturing (70 percent), wholesale (71 percent), and transportation (69 percent) have the highest likelihood of offering health benefits to their workers. Among the types of firms less likely to offer health insurance are construction firms, of which only 33

percent offer health benefits, and retail firms, of which 45 percent offer health benefits to their employees.

Employers in South Dakota offer health insurance for many reasons ***(Figure 6).*** According to 38 percent of employers, the *most important* reason they offer insurance is to attract or retain workers. Another 21 percent assert the *most important* reason they offer insurance is to ensure that employees remain healthy. Respondents highlighted many reasons they offer health insurance to their employees. The four most prevalent reasons employers report they offer health insurance to their employees include: to attract or retain workers (86 percent); employees want or expect it (85 percent); to ensure employees remain healthy (84 percent); and to be a good corporate citizen (81 percent).

Figure 6
Reasons Employers Offer Coverage



Source: Lewin Group Survey of Employers in South Dakota, conducted by Baselice & Associates, Inc. (Fall 2001).

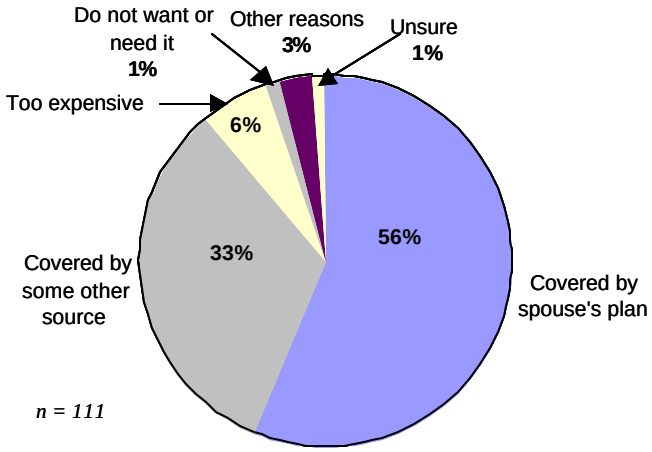
3. Variation in Coverage Offered by Employers

Among firms in South Dakota that offer health insurance, 92 percent of full-time employees are eligible for health benefits, on average. About 61 percent of insuring employers exclude part-time workers from receiving health benefits and 41 percent exclude seasonal workers. There are many reasons why employers exclude such workers. Fifty-nine percent of firms report they do not cover part-time or seasonal workers because the company isn't required to do so. In addition, coverage of part-time and seasonal workers is considered too expensive by most employers (56 percent) and nearly half of them (48 percent) say coverage isn't needed to attract or retain workers. Of most significance is the employer perception that their part-time and seasonal workers are covered elsewhere (50 percent).

The percent of the worker's insurance premium that is paid by employers varies among firms. While 21 percent of employers report they pay up to 50 percent of the premium, 50 percent of firms report they pay the entire worker premium. On average, 81 percent of the worker's insurance premium is paid by private employers in South Dakota, according to survey results. Employer payment of dependents' insurance premium also significantly varies. Forty-three percent of private employers that offer health insurance in South Dakota do not contribute anything towards the cost of the dependents' insurance premiums. Eighteen percent report they pay all of the dependent's premium. On average, 39 percent of the insurance premium for employees' dependent coverage is paid by employers in South Dakota.

Fifty-five percent of employers in South Dakota that offer health insurance report that at least one of their employees declines the health coverage offered to them through work (Figure 7). According to the employers, the major reasons their employees decline coverage include: worker is covered by a spouse's plan (56 percent) and worker is covered by some other source (33 percent). The high cost of health coverage was cited by only 6 percent of employers as a reason their employees decline coverage.

Figure 7
Reasons Employees Decline Coverage



Source: Lewin Group Survey of Employers in South Dakota, conducted by Baselice & Associates, Inc. (Fall 2001).

Of the employers that offer health insurance in South Dakota, nine percent offer cash or additional pay in lieu of health benefits. The majority of employees offered cash alternatives to health benefits accept this additional pay instead of health coverage.

Seventy-five percent of employers offering health insurance in South Dakota are fully insured by a carrier, while 21 percent of employers are either fully self-insured or partially self-insured (with stop loss).[8] (The 21 percent figure translates into approximately 62 percent of employees working for private employers in the state.) Eighty-five percent of insuring firms offer only one health plan to their employees.

[8] Four percent of employers were unsure how their companies were insured.

- 16 percent offer an HMO plan
- 37 percent offer a PPO plan
- 21 percent offer a traditional fee-for-service or indemnity plan

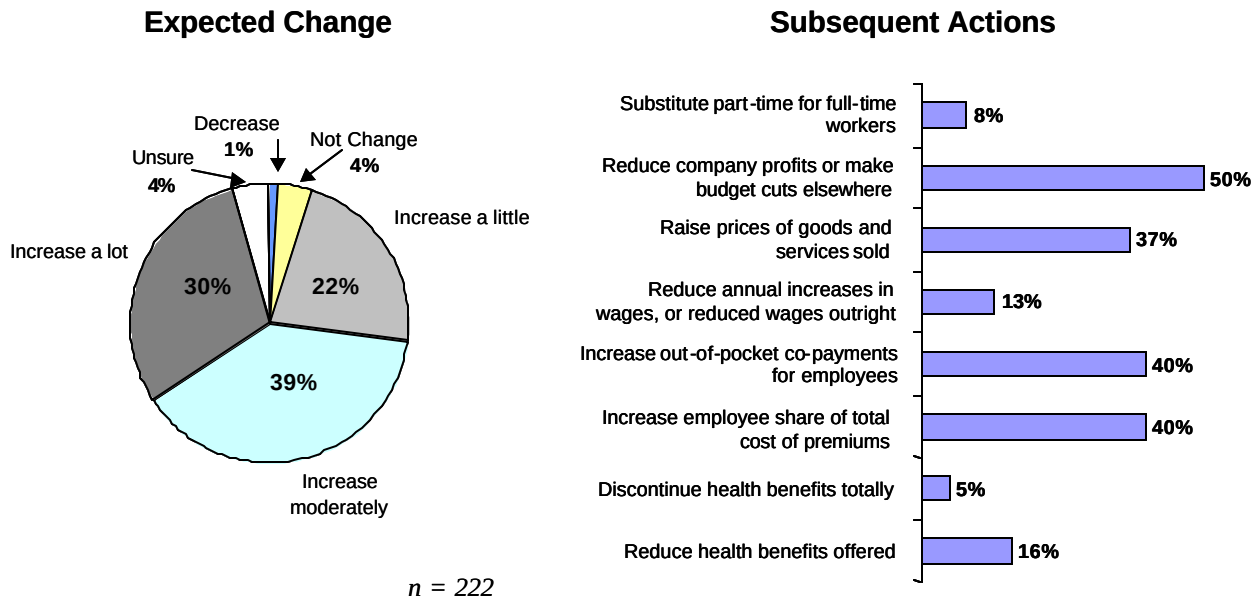
Prescription drug benefits are offered by 86 percent of insuring employers as either part of their health plans or as a separate benefit, according to survey respondents.

About three percent of employers report that some of their employees are excluded from health coverage because of particular health problems or pre-existing conditions.

4. Cost of Health Insurance

Employers who offer health insurance to workers overwhelmingly asserted that premiums they pay will increase in the coming year (91 percent of insuring employers). Thirty percent of insuring firms expect health insurance premiums to "increase a lot." As a result of these price increases, five percent of firms expect to discontinue offering health benefits. Most (50 percent of insuring employers) expect to reduce company profits or make budget cuts elsewhere. Companies also expect to transfer some of the premium cost increases to employees through increased co-payments (40 percent) and increased share of total premium costs (40 percent) ***(Figure 8)***. Thus, the increasing cost of health care is borne by employers and employees alike.

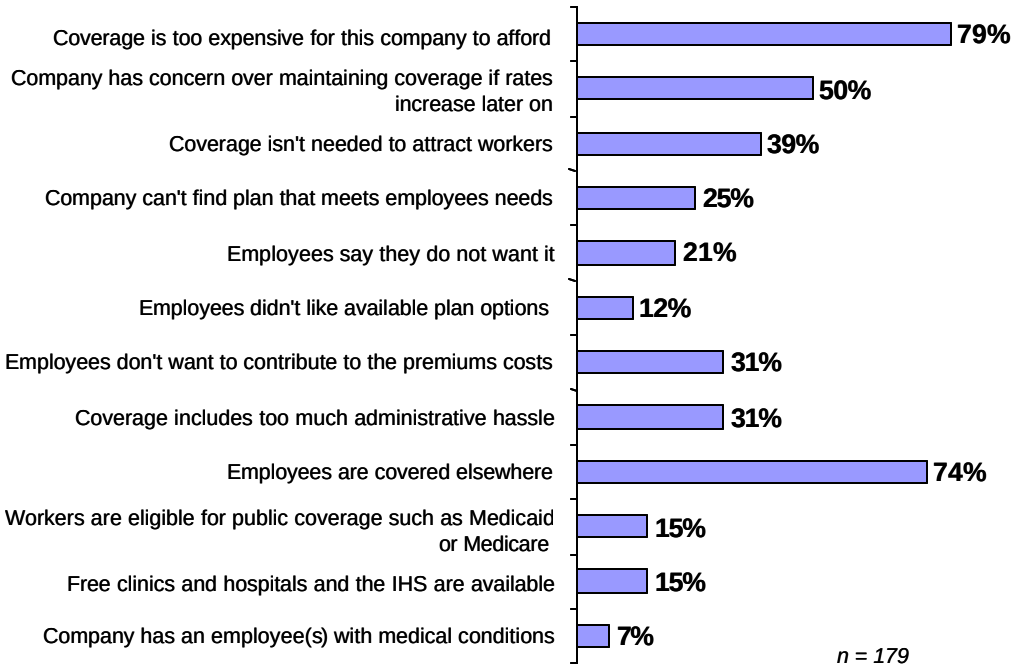
Figure 8
Expected Change in Future Health Premiums



Source: Lewin Group Survey of Employers in South Dakota, conducted by Baselice & Associates, Inc. (Fall 2001).

The high cost of health insurance is the major deterrent to South Dakota firms offering health benefits to their employees. Among non-offering firms, over 46 percent stated the *major reason* they do not offer coverage is high cost. When firms were asked about the *many reasons* they do not offer coverage, 79 percent reported that coverage for employees was too expensive for the company to afford ***(Figure 9)***. Three quarters of South Dakota employers also reported that another major reason they didn't offer health coverage is that employees are covered elsewhere.

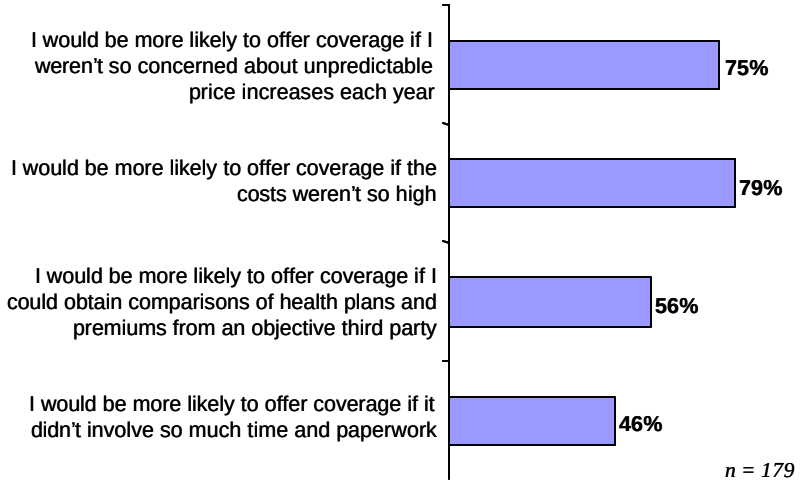
Figure 9
Stated Reasons Employers Do Not Offer Coverage



Source: Lewin Group Survey of Employers in South Dakota, conducted by Baselice & Associates, Inc. (Fall 2001).

Among non-insuring firms in South Dakota, seven percent dropped health insurance as a benefit in the past five years. Of those who dropped the benefit, nearly 70 percent did so because the premiums were too high. About half of all non-insuring firms considered offering health insurance to workers. The major reason they did not was because premiums were too high, according to survey results. Non-insuring employers reported they would be more willing to offer health coverage if premium costs weren't so high and year-to-year price increases weren't so unpredictable ***(Figure 10).***

Figure 10
Reasons Employers Would be More Likely to Offer Coverage



Source: Lewin Group Survey of Employers in South Dakota, conducted by Baselice & Associates, Inc. (Fall 2001).

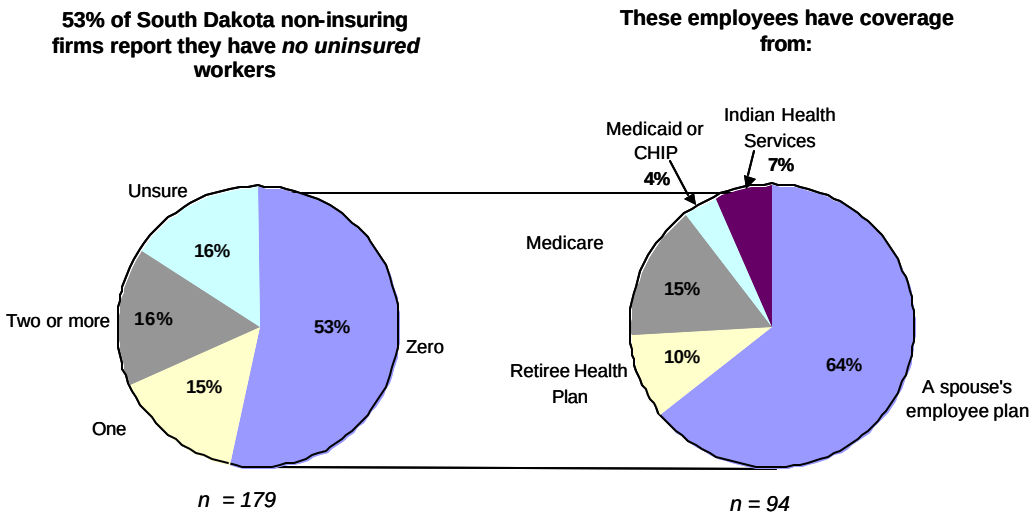
Instead of health insurance, employers may provide health benefits in other ways. Among non-insuring firms in South Dakota, 11 percent reported they contribute to the cost of coverage when an employee is covered by a spouse. Companies may also pay employees' medical bills directly (four percent of firms) or employ a nurse or doctor who provides care on-site (five percent).

5. Consequences of Not Providing Health Insurance

Despite the fact that 45 percent of South Dakota private employers do not offer health insurance, about 53 percent of South Dakota non-insuring firms reported that they have no uninsured workers. These firms were asked about where their employees obtain coverage. Sixty-four percent of non-insuring firms report that their employees are insured through their spouses' employment-based plan. Another 25 percent thought their employees were covered by either Medicare or a retiree health plan ***(Figure 11)***.

Results of the South Dakota Employer Survey indicate that employers recognize the possible adverse effects of not providing health insurance to their employees. As Figure 12 shows, 15 percent of firms report an awareness that some employees are unable to obtain needed care and 22 percent of firms have employees with large-out-of-pocket medical bills as a result of their not providing employer-based coverage. The consequences vary greatly by geographic area; 20 percent in the Pierre/Mobridge/Rapid City region report their employees are unable to obtain needed care and only seven percent in the Sioux Falls area. This variation may be attributed to greater access in Sioux Falls to medical facilities or community health centers.

Figure 11
Other Sources of Coverage for Workers at Non-insuring Firms



Source: Lewin Group Survey of Employers in South Dakota, conducted by Baselice & Associates, Inc. (Fall 2001).

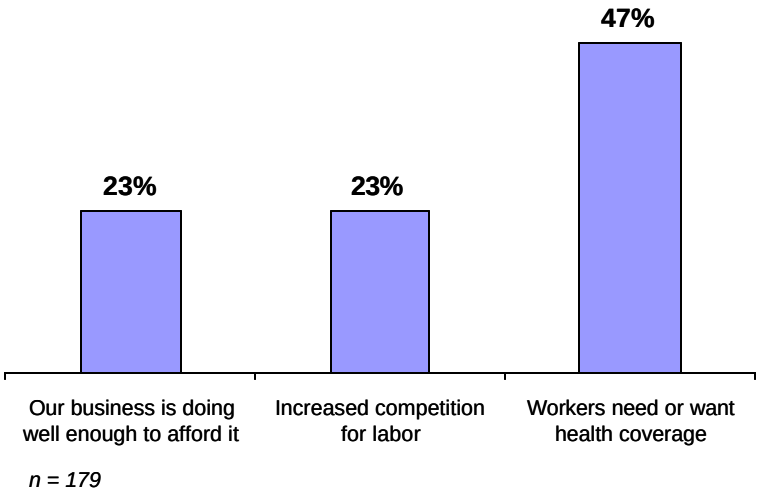
Figure 12
Consequences When Firm Does Not Offer Health Insurance

	Employee(s) Unable to Obtain Needed Care	Employee(s) Face Large Out-of-Pocket Medical Bills	Employee(s) Took New Job With Health Benefits
Overall	15%	22%	25%
Geographic Area			
Sioux Falls	7%	18%	27%
Watertown/Mitchell/Aberdeen	16%	19%	26%
Pierre/Mobridge/Rapid City	20%	27%	21%

Source: Lewin Group Survey of Employers in South Dakota, conducted by Baselice & Associates, Inc. (Fall 2001).

Employers also recognized that by failing to offer insurance, employees took new jobs that offered health benefits (25 percent of non-insuring firms reported this as happening in their company). In Sioux Falls where the job market is relatively competitive, employers reported a 27 percent rate of occurrence while in Pierre/Mobridge/Rapid City the rate is 21 percent. Indeed, the importance of health benefits to employees is a major reason why 17 percent of non-insuring firms plan to change their employee benefits package to include health coverage in the next five years ***(Figure 13).***

Figure 13
Reasons Why 17 Percent of Non-Insuring Firms May Add Health Coverage in the Future

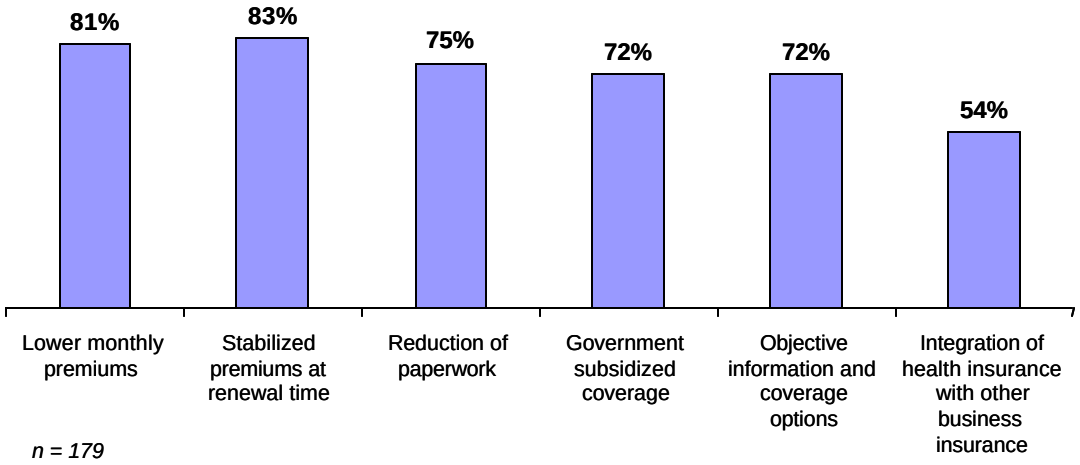


Source: Lewin Group Survey of Employers in South Dakota, conducted by Baselice & Associates, Inc. (Fall 2001).

7. What is Needed to Help Firms Increase Coverage

Three-quarters of non-insuring firms report they would be more likely to offer coverage to employees if health insurance costs weren't so high or if premium price increases weren't so unpredictable from year to year. According to firms that do not offer health insurance to their employees, there are many things that could be done to help firms offer coverage. Chief among them are lowered monthly premiums and stabilized premiums at renewal time ***(Figure 14).***

Figure 14
What is Needed to Help Firms Increase Coverage to Employees

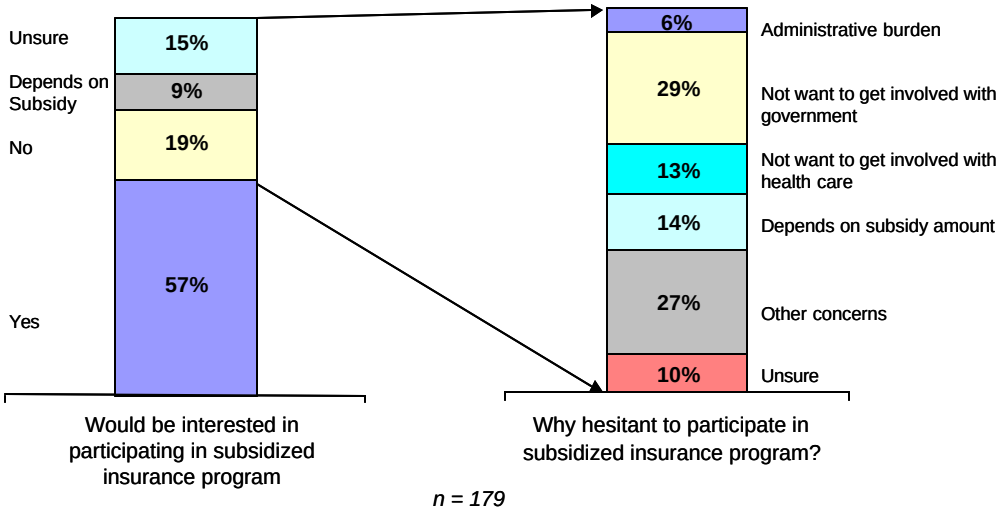


Source: Lewin Group Survey of Employers in South Dakota, conducted by Baselice & Associates, Inc. (Fall 2001).

Non-insuring firms were asked how much they might be willing to contribute each month towards the cost of coverage per employee. The majority of non-insuring firms (55 percent) were uncertain about whether they would pay any amount towards employee coverage. Over 18 percent were unwilling to contribute any amount. Over 15 percent reported they would consider up to $99 per employee per month. About 10 percent would consider between $100 - $200 or more per employee per month.

Because high premium costs often act as a deterrent for employers to offer health benefits to their employees, the survey asked non-insuring firms whether they would be interested in participating in an insurance program that was subsidized by the state or federal governments. Nearly 60 percent of non-insuring firms in South Dakota reported they would be interested in such a program. Among the 43 percent of respondents who were hesitant about participating in such a program or who did not want to, 29 percent reported they did not want to get involved with the government or the stigma of getting involved ***(Figure 15)***.

Figure 15
Willingness to Participate in Subsidized Insurance Program
(Percent of Non-insuring Firms)

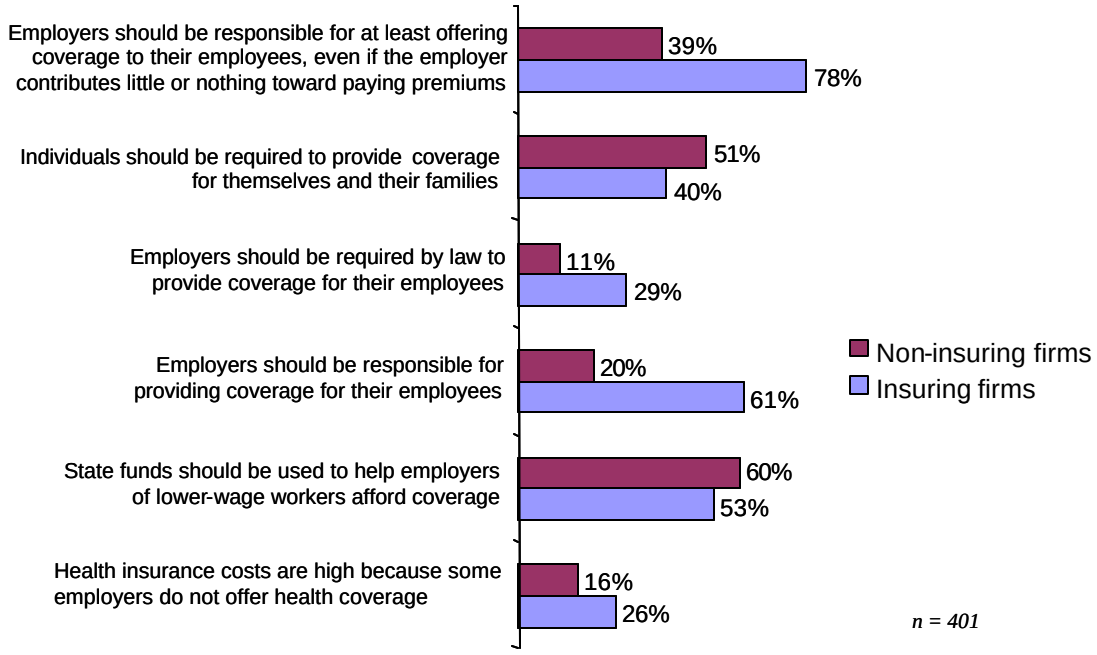


Source: Lewin Group Survey of Employers in South Dakota, conducted by Baselice & Associates, Inc. (Fall 2001).

8. Company Values About Employment-based Coverage

All surveyed employers were asked the same questions about corporate values concerning responsibility for providing health insurance to employees. As evidenced in ***Figure 16***, there are often great differences in perspectives among firms that offer health insurance to employees and those that do not.

Figure 16
Who Is Responsible?



Source: Lewin Group Survey of Employers in South Dakota, conducted by Baselice & Associates, Inc. (Fall 2001).

By far, the greatest value difference between insuring and non-insuring firms was related to the responsibility of providing coverage. Sixty-one percent of insuring firms believed that employers should be responsible for providing coverage to their employees; only 20 percent of non-insuring firms agreed with that statement. The two groups were somewhat similar in the belief that state funds should be used to help employers of lower-wage workers afford coverage, with 60 percent of insuring and 53 percent of non-insuring firms agreeing. Among both insuring and non-insuring firms, the value of individual responsibility for providing coverage for themselves and their families was expressed with more frequency than the value of corporate responsibility for health coverage.

Further complicating this subject is the difficult question of who ultimately bears the burden of, and responsibility for, health insurance costs. While many thought that employers, thus company profitability, shoulder the weight of paying for health insurable costs, employees may actually pay for their own increased benefits through reduced wages.[9] Sixty percent of non-insuring employers thought that their employees were unwilling to accept reduced pay rates to obtain health coverage. Private businesses are challenged between resistant employees on one side and the reality of high health premiums and limited alternatives for the company on the other.

[9] Mark V. Pauly, *Health Benefits at Work: An Economic and Political Analysis of Employment-Based Health Insurance*. Ann Arbor: University of Michigan Press, 1997.

B. Focus Groups of Small Employers

Focus groups that included entrepreneurs and small employers were asked questions designed to identify the factors that influence their decision to offer or not offer health insurance to workers. Perspective was also gained as to what options may be most appealing in order to increase affordable coverage in the state. Focus groups were conducted in September and October 2001.

Employers uniformly concluded that the cost of health insurance is a serious impediment to providing this benefit to workers. In addition, they thought there is not one single action that could be taken to solve the problem of the uninsured in South Dakota. They suggested that many different steps need to be taken simultaneously to address the issue. Some employers stated that they were not sure that insurance should always be tied to employment, as this practice exiles many individuals from coverage opportunity. Businesses with only a few employees expressed a particular frustration with the health insurance market in South Dakota. Farmers and ranchers, entrepreneurs, the self-employed, and those employed by small firms reported extensive frustrations in their attempts to find adequate and affordable coverage.

There was a belief expressed among small business owners that insurance companies are simply not interested in providing health coverage to small businesses. Most of the small employers reported that they were unable to find group plans for their employees and individual policies were prohibitively expensive. Some small employers have so much turnover and/or rely on part-time workers that they believe "it is not worth it" to offer health coverage. Others thought that the burden of "finding the best deal" and handling the administrative work associated with insurance plans is enough to deter any small employer from offering health insurance. Several employers noted how disadvantageous the American health insurance system is to entrepreneurs who attempt to start their own business.

Employers reported they would be influenced by certain incentives including: expansion/development of purchasing alliances or individual or employer subsidies. Small business employers asserted there is a significant need for a modified small group health insurance market and that they would value assistance in "getting into" an adequate insurance pool. Many of the small businesses, including small farming operations, reported that when they have inquired about health insurance, the number of people they want to insure is too low to qualify for an affordable small group plan. Subsequently, their only choice is to pay extraordinarily high premiums or have deductibles so high that the policy becomes a "catastrophic" plan only to be used in cases of extremely expensive emergencies.

The most persistent complaint from small employers in the focus groups involved the dramatic price increases in the health insurance plans they currently have. Many employers reported an increase of over 10 to 20 percent for 2002. Many small employers expressed a desire for the government to institute regulations over how much health insurance costs could increase from year to year.

C. Structured Interviews

Interviews with business leaders and many stakeholders in the health care system yielded information that was often similar to the perspectives offered by survey respondents and focus

group participants. From an employer's point of view, continually rising health premium costs is a major factor affecting the provision of health insurance. As premium costs rise, young workers (and their families) will often forgo insurance and take the risk of medical adversity. Said one interviewee, "The higher the rates go, the more people go uninsured." In addition, many "mom and pop" businesses with a few employees don't qualify as a group, especially when potentially eligible workers decline to participate in the business' health plan. Older workers, often with pre-existing conditions, have difficulty getting coverage if they work for small firms because of their high medical risk.

In attempting to hold down premium costs for their workers, businesses are confronting what seems to be a growing problem. What small businesses can offer workers for health benefits is becoming increasingly catastrophic in nature. Employers who provide coverage for their workers are finding that they can't offer the same level of health care as in the past. Workers facing monthly premiums that seem high in relation to their wages (wages that are "lower than anywhere else in the country," according to one interviewee) also resist being required to pay $2,000 - $5,000 deductibles. As a result workers, especially young and healthy ones, will often decline employment-based coverage.

Another area of difficulty for employers is the aging and declining population of much of South Dakota businesses. Said one interviewee, "we want to hang on to each employee, including older ones, but it is getting so expensive." In addition, if business people retire at 55 years and sell the business, "keeping their insurance becomes a major issue." Employers also struggle in providing health coverage for their workers because of other economic forces:

- Large areas of the state (mostly western and center) have much seasonal employment due to the tourism and agricultural sectors;
- limited industry and manufacturing and "not much economic vitality;"
- high rates of disability in the state, "perhaps due to the nature of work here;"
- farmers and ranchers have their "hands tied in terms of raising prices. They go without health care because it's so expensive for single plans;"
- "low wages are the biggest barrier to enacting health coverage expansions in South Dakota," asserted one business leader.

Several interviewees highlighted the problem from a business point of view of recruiting and retaining health professionals, especially because cities in adjacent states can hire them "at twice the salary and give them better working conditions."

D. Conclusion

Throughout this research, the project team learned that the experience of South Dakota employers is similar to that of employers throughout the United States in terms of factors that affect the availability of job-based benefits and employers' concern about the high cost of offering health insurance. The high cost of health insurance is a major factor influencing

employers' decisions not to offer coverage to workers. Employer-based coverage is a complicated issue fraught with subtle complexities. While large employers offer insurance in order to attract employees, small businesses face different constraints as they pay high premium rates attributed to their small risk pools. What makes employment-based coverage in South Dakota unique compared to many other areas of the United States is the small percentage of employers that are self-insured and the small percentage of employers that offer HMO and PPO plans. The implication of this difference is that South Dakota employers may have less leverage than elsewhere to assure value-oriented purchasing of health coverage for their workers.

The South Dakota Survey of Employers was designed to increase policymakers' understanding of the issues and challenges employers face in offering health insurance to their workers. This telephone survey, combined with focus group findings (described elsewhere), and stakeholder interviews, yielded both quantitative and qualitative information that can help guide the development of approaches to make employment-based coverage more feasible in the South Dakota workplace. A number of options are available that would make employer-based coverage more feasible and appealing to employers in South Dakota. Namely, by the government offering tax incentives, clear unbiased information about the insurance market, pooling small business owners, and regulating health insurance rates and increases, the picture of employer-based coverage could improve dramatically in the state.

SECTION III: SOUTH DAKOTA'S HEALTH CARE MARKETPLACE

As part of the SPG project, the Interagency Work Group and Lewin conducted a review of the South Dakota health care system and marketplace. We began by identifying the unique population, and geographic and health sector characteristics of the state. The team also assessed the adequacy of health coverage in the state, examined competition in the health care and insurance sectors, we reviewed available data on providers in the state to indicate whether there is sufficient provider capacity to meet any increase in demand for health services that could occur among newly insured people if coverage expansion options were enacted. Next, we reviewed South Dakota's health spending by type of service.[10]

The remainder of this chapter is devoted to answering questions posed in HRSA's guidance for preparing final reports.

A. Population Characteristics and Availability of Health Care Resources

One almost needs to visit South Dakota to appreciate how its vast geography and low population influence how policy makers view health care and coverage issues. The state's land area is 75,885 square miles, much larger than the combined area of all of New England. The state has three main groupings of population: urban, rural, and frontier. About one-third of the land area in South Dakota is dedicated to nine Native American reservations.

The 2000 Census revealed that South Dakota's population grew to 754,844 persons, averaging 9.9 persons per square mile (compared to U.S. average of 79.6).[11] Most of the population growth occurred along the state's Interstate highway system. Of the 22 counties bordering either I-29 (which runs north/south along the state's far eastern side) or I-90 (which runs east/west) the population grew by 54,659, or 13.3 percent. Interestingly, the population of the remaining counties also grew slightly, owing primarily to population increases on Indian reservations.

South Dakotans have relatively low average incomes compared to the U.S. population as a whole. Strict interpretations of financial information can be misleading, however. The state's median household income is lower than that of the U.S. in 2000 ($35,205 and $41,349 respectively[12]); yet, if one takes into account taxation levels and lower consumer costs the state ranks 28th in "purchasing power." The state also exhibits many contrasts. Two counties in the state, Shannon and Todd, are among the poorest in the country and also have the shortest life expectancies.

In 1999, South Dakota had an estimated 534 full-time equivalent (FTE) primary care physicians, and 292 FTE mid-level health care providers. The availability of nurses is a particular issue for

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[10] These assessments were conducted using published data sources on health services utilization and expenditures in the state as well as interviews with state officials and outside stakeholders. State data on health expenditures was provided by the Centers for Medicare and Medicaid Services (CMS), Office of the Actuary. Data on provide capacity and insurance regulation was provided by the South Dakota Department of Health and Division of Insurance.

[11] http://quickfacts.census.gov.qfd

[12] http://factfinder.census.gov/home. Estimates based on twelve monthly samples during 2000.

the state. About 10,000 RNs are currently licensed; but over 500 RN vacancies exist currently in health care organizations and more than one-third of South Dakota RNs will be eligible to retire in the next 10 years. The projected annual need for new RNs is about 400, yet only about 320 RNs are newly licensed to practice each year. The state has recruitment programs for all three professions, primary care physicians, mid-levels and nurses.

In addition, as of March 1, 2002, the state had 22 federally qualified health centers, 57 rural health clinics, 50 community health services offices, and 12 Health Alliance counties. Finally, in South Dakota, there are 51 general community hospitals, of which 27 are critical access hospitals, as well as five Indian Health Service hospitals and three Veterans Administration hospitals. (A map of these hospital providers appears in ***Appendix G.***) Long-term resources include: 116 nursing homes, 111 assisted living centers, 62 residential living centers, 72 home health providers, and 27 hospices.[13] The Critical Access Hospital (CAH) Program, in particular, has been important for South Dakota. Early on, state officials saw the need for a program that lessens certain restrictions on small hospitals and provides enhanced reimbursement in order to reduce the fragility of the local health care system. South Dakota was a pioneer of the CAH program, having participated in a seven-state demonstration program prior to the program being implemented nationwide.

There are three major hospital systems in the state: the Sioux Valley Health System, the Avera Health System and the Rapid City Regional Hospital Health System. These facilities all have tertiary care hospitals which are responsible for the majority of admissions in the state. Each operates an extensive system of hospitals, health care centers/clinics, long-term care facilities, and other entities.

The adequacy of the health workforce in South Dakota is mixed.

- With 165 physicians per 100,000 population, the state falls below the national ratio of 198 physicians per 100,000 population and ranks 38th among states in physicians per capita.[14]
- The rate of primary care physicians per 100,000 population in South Dakota (84.7) is lower than the national rate of 91.7.[15] In South Dakota, over 28 percent of the population have no access to primary care, compared to 17 percent for the nation as a whole.
- There are 27 physicians assistants per 100,000 in the state, nearly three times the national average.[16]
- The state ranks 45th among states in both psychiatrists and psychologists per capita.[17]

According to HRSA data for 1999, South Dakota has shortages in many areas that are considered to be medically underserved. ***Figure 1*** compares the adequacy and availability of medical services between South Dakota and the United States along many dimensions.

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[13] SD Department of Health. *South Dakota Health Check-Up,* January 1999, updated by DOH staff.
[14] ftp://ftp.hrsa.gov/bhpr/workforceprofiles/southdakota.pdf
[15] http://stateprofiles.hrsa.gov/StateProfielsIndex.html
[16] ftp://ftp.hrsa.gov/bhpr/workforceprofiles/southdakota.pdf
[17] *ibid*

Figure 1
Indicators of Areas of Unmet Need[18]

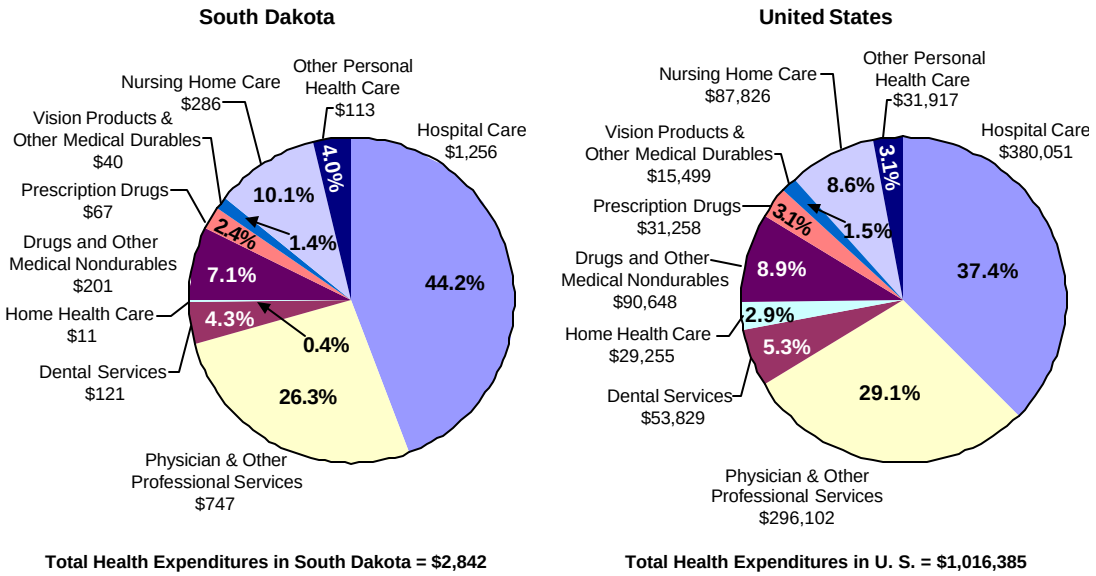
	South Dakota	United States
Percent Counties, Health Professional Shortage Areas (HPSA)	94.0%	82.2%
Percent Counties, Primary Care (HPSA)	76.1%	64.6%
Percent Counties, Dental (HPSA)	19.4%	26.9%
Percent Counties, Mental Health HPSA	62.7%	53.2%
Percent, Medically Underserved Areas (MUA)	83.6%	80.5%

B. Health Spending in South Dakota

This section examines health care spending in South Dakota. The review presented is based upon the national Centers for Medicare and Medicaid Services (CMS) State Health Expenditure (SHE) Accounts, Office of the Actuary. These accounts are the most reliable and credible source of all health spending data by state. The data capture health care expenditures by establishment and place of service (e.g., hospital, physician's office, nursing home, home health agency, etc.).

Health spending is reported by location of provider, not residence of the beneficiary. ***Figure 2*** shows the 1998 health expenditure data from all payment sources for South Dakota compared to the United States.

Figure 2
Health Expenditures in South Dakota and the United States, by Place of Service, 1998 (in $millions)



[18] http://stateprofiles.hrsa.gov/stateprofilesindex.html

Total health spending in South Dakota in 1998 was approximately $2.84 billion dollars, or about .27 percent of the national total of roughly $1.02 trillion. Hospital care comprised the largest portion of health spending in South Dakota, accounting for $1.256 billion (44.2 percent). The next largest categories of health spending were physician services (26.3 percent), nursing home care (10.1 percent), and drugs and other medical non-durables (7.1 percent). Although the hospital portion of health expenditures in South Dakota is greater than for the United States as a whole, the distribution of expenditures across services in South Dakota is similar to the U.S.

C. Adequacy of Existing Insurance Coverage

Data collection during the South Dakota SPG program yielded some indications about the adequacy of individuals' health coverage and how perceptions are different depending on the population group considered. Adequacy of health coverage was considered by survey respondents, focus group participants, and participants in structured interviews. Based on this information, the Interagency Work Group has become aware of the potential problems of *underinsurance* among some population groups in the state.

Adequacy of health coverage has been defined in the public health literature in a variety of different ways. The definition usually includes some minimum standards for insurance, such as the particular health benefits that are covered; the amount of required out-of-pocket expenses for individuals; and some measure of consumer access to medical care providers. Survey respondents and focus group participants in the SPG project considered various dimensions of the term "adequacy." It is apparent there is wide variation among consumers, employers, states, and federal agencies about how adequacy of health coverage should be considered.

1. Adequacy as Considered by Insured Consumers

While conducting the survey of the uninsured, an abbreviated questionnaire was completed for individuals who were "screened-out" because they were insured (described in Section I of this report). All insured respondents were queried about the adequacy of their health coverage. Eighty-eight percent of insured South Dakotans surveyed consider their existing health insurance coverage as either "adequate" or "very adequate."

One health benefit that is increasingly important in assessing the adequacy of health coverage is coverage for prescription drugs. As described in Section I, nearly three-quarters of the insured respondents indicated that their health insurance plan does cover prescription drugs.

2. Adequacy as Considered by Employers

The SPG project surveyed over 400 private employers in South Dakota (as described in Section II of this report). One consideration among employers of the adequacy of health insurance they offer is the out-of-pocket expenses incurred by employees in the form of cost-sharing. Employers were questioned as to the proportion of the total premiums that they paid; this provides a proxy measure of insurance adequacy. Of the firms that offer health insurance to their employees in South Dakota (*n=222*):

- 50 percent reported that they paid all of the insurance premium for worker coverage;
- Three percent paid 81 to 90 percent of the workers' premiums;
- 21 percent paid 51 to 80 percent of the premium;
- 21 percent paid up to 50 percent of the premium;
- One percent paid none of the premium; and
- Four percent were unsure of how much of the insurance premium they paid.

The majority (86 percent) of private employers surveyed that offer health coverage include prescription drug benefits either as part of their company's health plan or as a separate benefit, suggesting another possible (proxy) indicator of coverage adequacy.

3. Adequacy as Considered by Focus Groups

The focus groups conducted as part of the SPG project provided a consumer's perspective of the factors that determine adequacy of coverage for both individuals and small business employers. (A full report of the focus groups appears in ***Appendix D***.)

The majority of individuals in focus groups who *did* have health insurance reported they were either *underinsured* (that is, they had high deductibles or catastrophic plans) or *uneasily insured* in that they had deep fears about premium increases or of being dropped from the company that provided them health insurance. Lower income individuals, those with chronic medical conditions, and adults between 50 to 64 years of age expressed particular difficulties in securing affordable and adequate health insurance.

Focus group participants who were farmers or ranchers, or self-employed, or employed by small firms that didn't offer health benefits reported the most extensive frustrations in their attempts to find adequate and affordable health coverage. Individuals who were seeking non-group policies and businesses with only a few employees (either working in the business or workers who wanted health insurance) reported health policies with high out-of-pocket expenses and significant premium price increases for 2002. These individuals expressed dissatisfaction with the adequacy of their coverage for the following reasons:

- They were being dropped by insurance carriers for reasons that seemed beyond the individual's control even though they had loyally paid monthly premiums for years;
- They experienced unexpected limits in benefits, usually at the time a serious medical crisis confronted either themselves or a member of their family; and
- They were faced with unexpectedly low payment amounts to providers by plans when medical claims were processed.

4. Perceived Differences of Adequacy Between Insured Respondents and Focus Group Participants

Although 88 percent of *insured* respondents ("screen-outs") indicated that they thought their health care coverage was adequate, focus group members were dissatisfied with the adequacy of their health care coverage. This is because they were either uninsured or they had individual coverage which was limited in benefit scope and had high co-pay requirements; insured respondents primarily had employment-based coverage which is typically more comprehensive.

Other factors may also account for differences in perception of coverage adequacy.

- **Differences in household income.**

  Insured respondents' household incomes were higher, on average, than uninsured survey respondents (see Section I). Focus group populations tended to be poorer than the general population in the state (as indicated by their reported livelihoods). For them, having health coverage was regarded as a trade-off with other important household expenses. Because the focus group participants tended to be lower income, they often reported problems with the *affordability* of health coverage, which contributed to their perceptions that their health plans were not *adequate* in terms of financial protection. It is likely that the scope of health benefits that is affordable to low-income persons is more limited than a health plan affordable to a person with a higher income.

- **Differences in health status.**

  The insured may be healthier, in general, than focus group participants. Focus group participants often initiated discussions about their personal health problems and numerous encounters with the health care system. Such discussion was expected given the fact that many of the groups chosen (e.g., near elderly and lower-income individuals) are not as healthy, on average, as the typical South Dakotan. As a result, it is likely that focus group participants had more experiences with many providers in the medical care system and were more likely to have confronted frustrations with, or inadequacies of, their insurance coverage than individuals who were adequately insured.

5. Adequacy as Considered by Structured Interviews

The SPG project team completed interviews with knowledgeable spokespersons of provider and insurance groups and other key consumer and business stakeholders in the state. These structured interviews provided qualitative information on the factors affecting health coverage in the state. Many of those interviewed confirmed the perspectives of focus group participants and gave additional examples of inadequate health coverage, including underinsurance.

- One advocate indicated that lack of affordability of health coverage limits the adequacy of health care that is available. Because the economy in South Dakota is depressed and largely agricultural in its base, the average income of residents remains low; thus, people can't afford to obtain adequate health coverage.
- Another respondent highlighted the problem of the lack of prescription drug coverage in many plans, especially among the elderly.

- A business leader reported that there are large numbers of people in the state who are underinsured. He observed that many health insurance plans do not cover needed health benefits, even though policy premiums are high. While catastrophic medical disasters are often covered, many other essential health services often require large out-of-pocket expenses and deter timely access to care.
- Another respondent estimated that about one-third of business owners in the state offer catastrophic coverage with a "huge deductible."
- An insurance company representative indicated that the high cost of health insurance may force many participants of small group plans into the individual market. To make matters worse, many carriers are pulling out of the individual market and leaving the state. Business leaders interviewed seemed to agree that there is a shortage of non-group policies available in the state, which contributed to the lack of adequate coverage offered. As more insurance companies exit the market, there is less competition among remaining carriers, which puts the state's population at risk for higher premium costs.
- One human services advocate highlighted the difficulty that individuals with either physical disabilities or mental illness face in securing health coverage. There is a "sizeable disabled population in South Dakota." Persons with disabilities may secure Social Security Disability Insurance (SSDI) but must wait 24 months to quality. The disabled may receive Medicare benefits; Medicaid can be available to persons with very low income and limited assets. For individuals with mental illnesses, high bills for prescription drugs, as well as large co-pays and deductibles is a problem, as private insurance for persons with mental illnesses is often limited in scope. As a result, many individuals with mental illness also have to rely on Medicaid.

6. Accessibility of Medical Care

The independent and direct effect of health insurance coverage on access to health services is well established, according to a recent Institute of Medicine report.[19] Generous benefits and low co-payments may make health coverage seem adequate; however, if needed medical care cannot be accessed – for whatever reason – then value of coverage is diminished. For example, in many areas of the United States, persons insured through managed care plans may be frustrated when providers of choice are not included in their plan's panel of preferred providers.

In South Dakota, medical care may be inaccessible to individuals for other reasons. Care may be inaccessible to those who need it regardless of their income, health status, or insurance coverage, according to state officials, focus group participants, and stakeholder interviews. This is because as a rural and frontier state, many medical provider specialties may be located hundreds of miles from citizens who need care. In addition, there is a shortage of many types of medical providers in the state (as described earlier in this section). Most counties in the state have been federally

[19] Institute of Medicine, Committee on Consequences of Uninsurance. *Coverage Matters: Insurance and Health Care.* Washington, DC: National Academy Press, 2001, p. 28.

designated as medically under-served areas.[20] Finally, recruitment and retention of medical providers, especially nurses, remains a serious problem in many areas.

D. Variation in Benefits

One of the questions posed by HRSA was the extent of variation in benefits among non-group, small group, large group, and self-insured plans. The SPG project in South Dakota did not explicitly investigate variation in benefit design among different sized groups.

E. Prevalence of Self-insured Firms

Self-insured firms are far less prevalent in South Dakota than elsewhere in the United States. As a firm decreases in size there is a higher potential risk in self-insuring against employees' medical expenses, a relationship noted by several of the individuals who participated in the structured interviews. In South Dakota, approximately 70 percent of the private employers who participated in the SPG Survey of Employers had from two to ten employees. Because firm size tends to be small in South Dakota, few self-insure in the state. According to the employer survey, 21 percent of employers that offer health benefits to their workers are either fully or partially self-insured. (This 21 percent of firms employs 62 percent of workers included in the survey.)

The proportionately small number of self-insured firms in South Dakota has an impact on the state's health insurance marketplace. The specific impact may be inferred from national studies and court decisions over the years. As interpreted by numerous court decisions, the Employee Retirement Income and Security Act (ERISA) of 1974 precludes self-insured plans from state regulations such as reserve standards, mandated benefits, premium taxes, and consumer protection requirements. Insurance companies throughout the nation have claimed that state regulations of premiums can lead to increases in premium prices and health care spending for employees. Because self-insured firms may be better able to tailor health benefits to what employees want and can afford, many employers have asserted that self-insurance has the potential to expand health care coverage among workers and their dependents.

State policy makers throughout the United States would generally agree that ERISA's broad preemption clause (that supercedes state laws) has prevented states from requiring all employers to offer workplace coverage or from directly regulating private employer-sponsored health plan benefits or solvency.[21] States cannot require employer-sponsored health plans to participate in purchasing pools or to coordinate with public health care coverage programs. The fact that most private businesses in South Dakota, as well as all of state government, are not affected by ERISA provisions suggests that the State's Department of Commerce and Regulation has the potential to establish health insurance guidelines and insurance market reforms that have broad applicability across insurers and carriers in the state.

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[20] Approximately 180,000 South Dakotans reside in MUAs.

[21] See Patricia A. Butler: *ERISA and State Health Care Access Initiatives: Opportunities and Obstacles.* New York: The Commonwealth Fund, October 2000.

F. State as a Purchaser of Health Care

There are many important roles that state governments play in the health care field. They include: protecting public health and safety; providing health care directly; purchasing health care; developing and training health care professionals; establishing rules governing health care provider entry into the market; and establishing rules governing health care marketplace activities.[22]

South Dakota state agencies, particularly the Department of Health, focus their policy attention or many specific health areas other than health care purchasing. Protecting the public's health and safety is a priority.[23] The State supports numerous child health promotions and chronic disease prevention programs. The State surveys and licenses health facilities to assure patient quality and safety. The state directly delivers professional nursing and nutrition services and coordinates health-related services to individuals, families, and communities across South Dakota. These services are delivered at State Health Department offices. In a few Public Health Alliance sites, services are delivered through contracts with county governments and private health care providers.

The State's Division of Insurance, within the Department of Commerce and Regulation, provides important oversight of the health insurance market in the state. The Division investigates consumer complaints and takes legal action against insurers who violate state laws. It reviews rate increase requests from insurers, monitors compliance with solvency and other business requirements, and protects consumers against insurance fraud.[24] The Department also oversees health professional licensing boards and commissions in the state.

The State of South Dakota's role as a purchaser of health care is less of a priority than other roles, as described above. The State can influence the purchase of health care through its Medicaid program and the administration of health benefits to State employees. There is a limit to how aggressively the State can use its purchasing power, however, to change the health care delivery system. This is because South Dakota's geography and chronic shortages of health providers in many areas impede the development of State purchasing strategies that have been implemented in many other areas of the United States. Another reason for limits in the State's role as purchaser is that public spending on health care in South Dakota is comparatively small.

Public expenditures for health care in South Dakota are proportionately lower than those in other states compared to private sector spending. Medicare and Medicaid payments for personal health care in South Dakota comprised 30 percent of all payments for personal health care (including private insurance and individual out-of-pocket payments), compared to 36 percent for

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[22] Alpha Center classification developed for AHRQ User Liaison Program Workshops; based on Altman and Morgan's "The Role of State and Local Government in Health," *Health Affairs*, Winter 1983.

[23] For example, Governor Janklow initiated a multi-phased effort enhancing the state's terrorism and bioterrorism preparedness in 2001. Because of ongoing and oftentimes severe provider shortages in South Dakota, the State has sponsored ongoing programs to train, recruit, and retain health professionals. During the 2002 Legislative Session, for example, new funds ($1.1 million) were appropriated to expand nurses training at two public universities.

[24] http://www.state.sd.us/dcr/insurance/index.htm

the nation as a whole.[25] South Dakota government expenditures for health programs and hospitals were estimated at $61.721 million and $44.67 million, respectively, in 1999.[26] Total Medicaid program expenditures (including all services and administration) were $368.5 million in SFY 1998. The State's share of this total was 31.7 percent in 2001. State spending for its employee health premiums totaled $47.2 million in FY 2001.[27]

G. Current Market and Regulatory Environment

Current market trends and the regulatory environment in South Dakota is characterized by a high proportion of small group and individual health plans, but the level of competition among companies offering these plans varies by specific market area. As reported in the SPG focus groups, many small group and individual insurance carriers are leaving South Dakota's market. From 1998 to 2002, the number of small group carriers dropped from 29 to fifteen.[28] The number of major medical carriers issuing new business in the individual market has dropped to eleven. One individual market carrier with significant market share submitted notification that it would cease marketing as of 2001 due to coverage mandates, inability to obtain an additional exemption from guaranteed issue, and the application of rating bands to previously issued products.[29] [30] Another way to view the state's health insurance market is to estimate the market share of the largest carriers in South Dakota. The three largest carriers for each insurance group dominate much of the market:

- Individual Market – 89 percent of total covered lives
- Small group – 53 percent of total covered lives
- Large group – 77 percent of total covered lives[31].

The implications of these estimates is that the health insurance market is highly concentrated in South Dakota, as in all states, particularly in the individual and large group markets. As most insurers have little market share, the largest insurers enjoy monopoly power and have some

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[25] http://www.hcfa.gov/stats/nhe-oact/stateestimates

[26] US Census Bureau, South Dakota State Government Finances: 1999. Available: http://www.census.gov/govs/state/99st42sd.html. Expenditures for health programs and hospitals include both direct and intergovernmental expenditures (such as expenditures to local governments). Health program expenditures include those for services and improvement of public health, other than hospital care and those services financed by other governments' health programs. Health program expenditures excludes vendor payments for medical appliances, supplies, or services under Medicaid. Expenditures for hospitals include the expenditures for the provision of care in public or private hospitals, including construction of hospitals. Because all expenditures of public hospitals are captured in the hospital category, a proportion of Medicaid expenditures may be captured in the hospital category, as well.

[27] http://www.state.sd.us/bfm/budget

[28] http://www.state.sd.us/dcr/insurance/LHRatesForms/IndMedCarriers.htm

[29] SD Division of Insurance, *Report on the Impact of Legislated Reform Measures on South Dakota: Individual and Small Employer Health Insurance Markets*. January 2001.

[30] It appears that the state's policy on providing coverage to those determined to be "uninsurable" because of previous or current medical conditions may have contributed to the carrier's exit. Under current law, companies offering individual policies must devote 2 percent of their premium volume to guaranteed issue.

[31] SD Division of Insurance, *Annual Average Premium Survey*, 2001.

discretion about pricing the policies they sell.[32] One member of the Interagency Work Group concluded, "The South Dakota insurance market is barely competitive. If the state continues to lose carriers, it will become less competitive." There are now 13 large group major medical carriers in the state. As of January 2001, there were four licensed HMOs in South Dakota and 9.7 percent of the state's population was enrolled in an HMO.[33]

As the SPG Interagency Work Group considers policy options to expand affordable coverage in the state, it is important that the fragile individual and small group insurance environment is stabilized in the process. At this time, it is unknown what, if any, regulatory changes could be made to accommodate policy option development.

H. Universal Coverage, Health Care Use and Providers

One of the most important issues for South Dakota to consider is whether providers in the state would have the capacity to meet consumer demand when and if health coverage is expanded to all residents of the state. This is because utilization of health care services would be expected to increase as the uninsured become covered. ***Figure 3*** presents estimates of the percentage increase in aggregate statewide utilization of health care services (including utilization for both the insured and newly insured) if the uninsured in South Dakota became covered. These data indicate that the most significant increase would be for physician and dental services.

Figure 3
Percent Increase in Aggregate State-wide Use of Health Care Services if Uninsured Become Covered

Type of Service	Percentage Increase in Utilization
Physician Visits	3.7%
Dental Visits	4.3%
Hospital Stays	0.7%
Outpatient Visits	2.6%
Emergency Room Visits	(0.9%)

Source: Lewin Group estimates using the South Dakota version of the Health Benefits Simulation Model (HBSM).

Because South Dakota is a sparsely populated state with a shortage of health care providers in many areas, it is expected that access to health care services could become an even more challenging issue as more persons in the state become insured. To the extent hospitals, physicians, and other health providers currently have capacity that exceeds patient demand, however, expanded coverage could increase the volume of services they deliver and thus,

[32] Chollet, D., Kirk, A., and Simon, K, *The Impact of Access Regulation on Health Insurance Market Structure*, submitted to the Office of the Assistant Secretary for Planning & Evaluation, US Department of Health and Human Services, October 2000.

[33] Lauer et al. *The Interstudy Competitive Edge, Part II: HMO Industry Report*. St. Paul, MN, October 2001.

improve their financial well-being. Estimating the specific impact on plans could not be fully assessed at this moment, given the information that is available and the time limitations of the HRSA SPG grant period.

I. Planning Process and Safety Net Providers

The SPG planning process in South Dakota did not specifically take safety net providers into account. During meetings and teleconferences with the Interagency Work Group, the importance of safety net providers in providing access to care was highlighted.

J. Experiences of Other States

Prior to drafting the policy alternatives to expand affordable health coverage, both the Interagency Work Group and The Lewin Group collected and evaluated information about programs in other state jurisdictions to assess their potential application in South Dakota. Lewin also applied its project team's policy and operational experience to assess the feasibility of public and private interventions proposed in the SPG planning process.

SECTION IV: OPTIONS FOR EXPANDING COVERAGE IN SOUTH DAKOTA

One of the primary objectives of the State Planning Grant (SPG) program in South Dakota was to evaluate the cost and coverage impacts of a wide range of options for expanding health coverage in the state. The Lewin Group analyzed six policy options, including changes to both public programs and private insurance. For each option, Lewin estimated the number of persons who would become insured and the cost of adopting each option. The analyses included estimating the number of persons *eligible* for each expansion, the number of eligible persons *who would accept* the coverage, and program costs. The six options evaluated include:

- Expanding Income Eligibility Levels for Adults under Medicaid and SCHIP
- Creating a Medicaid Buy-in Program for Small Employers and Low-Income Persons
- Creating a Private Health Insurance Premium Subsidy Program for Low-Income Persons
- Creating a Private Health Insurance Premium Voucher Program for Small Employers
- Creating a Low-Cost Option for Small Employers
- Expanding Direct Health Services

The estimates presented were developed using The Lewin Group's Health Benefits Simulation Model (HBSM) In brief, the HBSM is a microsimulation model of the U.S. health care system that has been applied in the analyses of thousands of legislative and regulatory proposals at the national and state levels for over 15 years. Lewin adapted this model for application in South Dakota by integrating state level data that are available through national and state sources. The (HBSM) model predicts the impact of health policy proposals by estimating the number of individuals who may be eligible for the proposed program, the number of individuals who are expected to enroll in it, and the cost of adopting the proposal (including the total costs and the distribution of costs among payers). The HBSM makes these comparisons among different policy options by using uniform data and assumptions; this approach yields a consistent platform for evaluation of multiple possibilities. A full description of the HBSM and its estimation methodology can be found in ***Appendix H.***

The options identified below were formulated from staff discussions within the Interagency Work Group and were based on policy options that have been considered or enacted in other states. The options were generated with the intent of exploring a range of potentially feasible approaches for expanding the availability of affordable health coverage in South Dakota. However, none of the approaches have progressed to the point where they are recommended for State implementation in 2002.

A. Option One: Expanding Income Eligibility Levels for Adults under Medicaid and SCHIP

This analysis examines the cost and coverage impacts of expanding Medicaid/SCHIP coverage to adults of various income levels in the state. Currently, South Dakota covers parents of Medicaid-eligible children up to 65 percent of the Federal Poverty Level (FPL).[34] Under Section 1931(b) of the Social Security Act, the state has the option to increase Medicaid income eligibility levels for parents to the same income level as children under the state's current State Children's Health Insurance Program (SCHIP), which is 200 percent of the FPL. The FPL for a family of three was $14,630 in 2001.[35] The federal government match for these newly eligible parents would be the current Medicaid match rate (68.31 percent in 2001)[36]. Some state dollars will be needed in addition to the available federal matching funds.

Under current law, no other non-disabled adults in South Dakota are eligible for Medicaid. However, the state could implement a coverage expansion for these adults without federal matching funds. In this analysis, we assume that these expansions are funded using only state funds. The Medicaid expansions for adults analyzed under Option 1 include:

- Covering all persons under 65 percent of FPL
- Covering all persons under 133 percent of FPL
- Covering parents and children below 200 percent of FPL and all other adults below 133 percent of FPL

Figure 2 shows The Lewin Group estimates for these Medicaid program expansions. Since children and parents are already covered if their incomes are less than 65 percent of FPL, the expansion to cover all such persons would add only adults to the Medicaid program. Nearly 33,000 adults would be eligible for coverage under this alternative. Of these, an estimated 17,000 would enroll in the Medicaid program. However, more than 5,000 of these new enrollees already have insurance coverage from some other source. Thus, about 12,000 uninsured persons would become insured with this expansion. This expansion would cost an estimated $35.2 million dollars, all comprised of state funds.

An expansion to all persons with incomes under 133 percent would expand eligibility to more than 58,000 persons. We estimate that about 32,300 would actually enroll in the program, including about 800 children (who become covered when their parents sign up), 5,500 parents, and 26,000 other adults. About 10,500 of the new enrollees would drop their current coverage to enroll in the public program, resulting in a net decrease of about 22,000 uninsured persons. This expansion proposal would cost nearly $78 million, of which South Dakota's share would be about $67 million.

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[34] Broaddus, M., Blaney, S., Dude, A., et. al. *Expanding Family Coverage: States' Medicaid Eligibility Policies for Working Families in the Year 2000*. Washington, DC: Center on Budget and Policy Priorities, February 2002.

[35] http://aspe.dhhs.gov/poverty/01proverty.htm

[36] http://aspe.dhhs.gov/health/fmap01.htm. In FFY 2002 the FMAP dropped to 65.93 percent in South Dakota.

Finally, the Medicaid expansion to parents and children below 200 percent of the FPL and all other adults below 133 percent of FPL would reduce the state's uninsured population by about 26,500 persons and would cost about $95 million. South Dakota's share of these expenses would be about $73 million.

Figure 2
Coverage and Cost Estimates of Selected Expansions in the South Dakota Medicaid/SCHIP Program (assumes no premium requirement) [a]

Eligibility Group	Avg. Monthly Number Eligible (thousands)	Avg. Monthly Number Enrolled (thousands)	Change in the Number of Uninsured (thousands) [b]	Total Costs (millions)	State Costs (millions)
All Below 65% of Poverty					
Children	--	--	--	--	--
Parents	--	--	--	--	--
All Other Adults	32.8	17.3	12.0	$35.2	$35.2
Total	**32.8**	**17.3**	**12.0**	**$35.2**	**$35.2**
All Below 133% of Poverty					
Children [c]	--	0.8	0.8	$0.7	$0.2
Parents	9.3	5.5	3.9	$15.6	$5.3
All Other Adults	49.1	26.0	17.1	$61.4	$61.4
Total	**58.4**	**32.3**	**21.8**	**$77.7**	**$67.0**
Parents and Children Below 200% of Poverty, Non-Custodial Adults Below 133% of Poverty					
Children [c]	--	2.6	2.6	$2.7	$0.7
Parents	19.6	10.5	6.8	$31.3	$10.7
All Other Adults	49.1	26.0	17.1	$61.4	$61.4
Total	**68.7**	**39.1**	**26.5**	**$95.4**	**$72.8**

a/ Assumes Medicaid benefits package with no premium requirement.
b/ The number of new enrollees who otherwise would have been uninsured.
c/ Some children who are now eligible but not enrolled in Medicaid/SCHIP would become covered as their parents become insured.

Source: Lewin Group estimates using the South Dakota version of the Health Benefits Simulation Model (HBSM).

Not all of the persons eligible to enroll in these Medicaid expansions currently lack health coverage. Some persons would drop their current source of health coverage to join the less expensive public program. This "crowd-out" phenomenon is believed by state officials to primarily affect those who currently have individual non-group coverage. However, national level studies indicate that this will occur among persons with employer coverage as well.

B. Option 2: Creating a Medicaid Buy-in Program for Small Employers and Low-Income Persons

Since many of the uninsured work in small businesses or have modest incomes, a program that would allow them to buy into the Medicaid program should reduce the number of uninsured persons in South Dakota. This option could be less costly than offering private insurance because provider payment rates and administrative costs under Medicaid should be less than that for private insurance in South Dakota.

Medicaid provider payment rates are lower than those of private insurance plans. According to the Medicare Payment Advisory Commission (MedPAC), Medicaid payment rates for hospital services are about 67 percent of private payment rates in South Dakota hospitals.[37] Medicaid payment rates for physician services are about 90 percent of Medicare payment rates in the state, which are also lower than private payment rates.[38] In addition, the Medicaid program gets a rebate of about 17 percent for prescription drugs compared to an average of about 8 percent under private health plans.[39]

The Medicaid program also has lower administrative costs than do private health plans. Medicaid program administrative costs in South Dakota equal about 3.4 percent of benefits costs, compared to administrative costs (including broker/agent commissions) for small groups, which can be as high as 30 percent of benefits costs.

The analyzed Medicaid buy-in option would allow persons in families with incomes below 200 percent of FPL to purchase coverage through the state's Medicaid program. The expansion would be geared for low-income workers (and their dependents) whose employers do not offer insurance coverage, and low-income persons in families lacking an employed adult.

Small employers also would be able to purchase coverage through the state's Medicaid program if they met the following criteria:

- They employed 50 or fewer workers;
- The average wages/salaries for their employees were below the state-wide average for small employers (i.e., less than $25,000 per year);
- At least three-quarters of their employees enroll;
- The employer has not offered insurance in the past 12 months; and
- Employers agree to pay at least half of the monthly premium.

No assumptions were made that were unique to this option about potential adverse selection. The premiums would be equal to the actuarial cost of the program and the cost of this program expansion would be fully funded through premium contributions on the part of small businesses or individuals. Thus, this approach would result in *no new costs* to the state.

Figure 3 displays the cost and coverage impacts of the Medicaid buy-in program for small employers and low-income persons. About 3,900 persons who work for small employers meet the criteria listed above. Of these, an estimated 3,700 would enroll in the program; about 2,800 of these enrollees would be previously uninsured.

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[37] Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy*, March 2001.

[38] Allen Dobson, et al, "Comparing Physician Fees Among Medicaid Programs," Falls Church: The Lewin Group, June 2001.

[39] Department of Health and Human Services, "Prescription Drug Coverage, Spending, Utilization, and Prices," April 2000.

Figure 3
Coverage and Cost Estimates of A Medicaid Buy-in Program For Small Employers and Low-Income Persons in South Dakota [a/]

	Number of Persons Eligible (thousands)	Number Who Enroll (thousands)	Newly Insured Persons [b/] (thousands)
Medicaid Buy-in Offered to Small Employers [c/]			
Currently Insured	8.7	0.9	--
Currently Uninsured	25.3	2.8	2.8
Total	**34.0**	**3.7**	**2.8**
Medicaid Buy-in Offered to Low-income Persons Without Access to Employer Coverage			
Currently Insured	22.7	5.9	--
Currently Uninsured	49.2	7.7	7.7
Total	**71.9**	**13.6**	**7.7**
Medicaid Buy-in Offered to Small Employers and Low-income Persons			
Currently Insured	27.6	6.7	--
Currently Uninsured	61.1	10.2	10.2
Total	**88.7**	**16.9**	**10.2**

a/ Low-income persons below 200% of poverty and small employers (50 or fewer workers) meeting the specified eligibility criteria would be eligible to buy into the Medicaid program.
b/ The number of new enrollees who otherwise would have been uninsured.
c/ About 34,000 workers and their dependents are in firms that would qualify for the program. However, it is estimated that only a portion of employers would be induced to purchase coverage for their employees.

Source: Lewin Group estimates using the South Dakota version of the Health Benefits Simulation Model (HBSM).

Of the 72,000 low-income persons (whose employer does not offer coverage or who is part of a non-working family) eligible for the Medicaid buy-in program, an estimated 13,600 would enroll. This includes about 7,700 workers and dependents whose employers do not currently offer health insurance and approximately 5,300 persons in non-working families. Out of the total 88,700 persons eligible for the buy-in program (including employees of small employers and persons with low incomes), an estimated 16,900 individuals would enroll. About 10,200 of these enrollees would have been uninsured. Some crowd-out occurs with this policy, as well.

This approach has the advantage that it can expand health coverage to nearly 11,000 individuals in South Dakota at no cost to the state. Premium contributions on the part of individuals and small businesses would fully fund this coverage expansion. Given the reported reluctance of providers to accept more Medicaid patients, however, the realized increase in medical access may be limited.

C. Option 3: Creating a Private Health Insurance Premium Subsidy Program for Low-Income Persons

Another option examined as part of the SPG project involves a premium subsidy for low-income persons who do not have access to employer-sponsored coverage. This policy would give a full premium subsidy to qualifying persons below 200 percent of the FPL. The subsidy would phase

out for persons between 200 percent and 300 percent of FPL. The subsidy, available to uninsured persons and those who purchase individual policies, would not apply to MediGap supplemental coverage for Medicare beneficiaries.

For illustrative purposes, we analyzed the cost and coverage impacts under the following three fixed-dollar subsidy amounts:

- Subsidy of $750 for individuals and $1,500 for families ($750/$1,500)
- Subsidy of $1,000 for individuals and $2,000 for families ($1,000/$2,000)
- Subsidy of $1,250 for individuals and $2,500 for families ($1,250/$2,500)

An estimated 99,300 persons would be eligible for a private insurance premium subsidy ***(Figure 4)***. About 47,200 persons would purchase insurance with the $750/$1,500 subsidy. The total cost of this option would be $26.7 million, approximately $567 per enrollee. About 11,300 persons who purchase insurance with the subsidy would have been uninsured. The subsidy cost for each newly insured person is an estimated $2,371. As the premium subsidy increases, more people would be induced to purchase insurance with it. Nearly 51,000 individuals would take advantage of the $1,000/$2,000 subsidy and about 54,000 individuals would use the $1,250/$2,500 subsidy. The per-enrollee cost of these subsidies is $765 and $963 respectively.

There are many approaches states have adopted to provide premium subsidies to low-income persons. They include tax credits; use of SCHIP funds to subsidize employer-offered health insurance; county/state contributions for employer-sponsored insurance among individuals working for small businesses; and others. Emerging research indicates however, that premium subsidies for individuals would have to be large (and costly) to have a noticeable impact on the number of uninsured in a state.[40]

D. Option 4: Creating a Private Health Insurance Premium Voucher Program for Small Employers

Another approach to expanding coverage in South Dakota entails directly subsidizing small employers to assist them in providing coverage to their workers. The state could accomplish this by offering vouchers to employers for a certain percentage of health insurance premiums for their workers. As envisioned in the design of this option, eligible employers would meet the following criteria:

- Their average per-worker payroll is below the statewide average for small firms; and
- They have not offered health insurance coverage to their workers in the past 12 months.

[40] Res Chovsky, J. and Hadley, J. "Employer Health Insurance Premium Subsidies Unlikely to Enhance Coverage Significantly," *Issue Brief #46,* Washington, DC: Center for Studying Health System Change, December, 2001.

Figure 4
Coverage and Cost Estimates of A Private Insurance Premium Subsidy For Low-Income Persons in South Dakota [a/]

	Number Eligible for the Subsidy (thousands)	Number Who Purchase Insurance (thousands)	Newly Covered Persons [/b] (thousands)	Total Subsidy Cost (millions)	Subsidy Cost Per Enrollee	Subsidy Cost Per Newly Covered Person
Subsidy of $750 / $1,500						
Currently Insured	35.9	35.9	--	$19.2	$535	
Currently Uninsured	63.4	11.3	11.3	$7.5	$668	
Total	**99.3**	**47.2**	**11.3**	**$26.7**	**$567**	**$2,371**
Subsidy of $1,000 / $2,000						
Currently Insured	35.9	35.9	--	$25.6	$712	
Currently Uninsured	63.4	14.9	14.9	$13.3	$890	
Total	**99.3**	**50.8**	**14.9**	**$38.9**	**$765**	**$2,600**
Subsidy of $1,250 / $2,500						
Currently Insured	35.9	35.9	--	$32.0	$892	
Currently Uninsured	63.4	18.1	18.1	$20.0	$1,104	
Total	**99.3**	**54.0**	**18.1**	**$52.0**	**$963**	**$2,872**

a/ Premium subsidies would be available to all persons below 300 percent of poverty who do not have access to employer-sponsored coverage. The full subsidy would be available to qualifying persons below 200 percent of poverty and is phased out for those between 200 and 300 percent of poverty.

b/ The number of new enrollees who otherwise would have been uninsured.

Source: Lewin Group estimates using the South Dakota version of the Health Benefits Simulation Model (HBSM).

For illustrative purposes, we analyzed the cost and coverage impacts of this option under four different scenarios:

- Vouchers are limited to firms with 10 or fewer employees;
  - Amount of the voucher is equal to 25 percent of the premium cost
  - Amount of the voucher is equal to 40 percent of the premium cost
- Vouchers are limited to firms with 25 or fewer employees;
  - Amount of the voucher is equal to 25 percent of the premium cost
  - Amount of the voucher is equal to 40 percent of the premium cost

The number of workers (including their dependents) in firms with 10 or fewer employees is about 24,900. The number increases to about 32,200 persons if the estimation includes firms with up to 25 workers. Depending on the generosity of the voucher program, the number of workers and dependents in firms that take the voucher varies from 1,500 to 3,300. Approximately 1,400 to 3,200 persons would accept the new coverage from their employers. The total subsidy cost of the program ranges from $600,000 to $2.3 million per year.

Figure 5
Coverage and Cost Estimates of A Private Insurance Premium Voucher Program For Small Employers in South Dakota [a/]

	Number of Workers and Dependents in Eligible Firms (thousands)	Workers and Dependents in Firms Induced to Offer Coverage (thousands)	Workers and Dependents Who Take Employer Coverage (thousands)	Newly Covered Persons (thousands)	Total Subsidy Cost (millions)
10 or Fewer Workers					
25 Percent Voucher					
Currently Insured	4.9	0.3	0.3	--	$0.1
Currently Uninsured	20.0	1.1	1.1	1.1	$0.5
Total	**24.9**	**1.5**	**1.4**	**1.1**	**$0.6**
40 Percent Voucher					
Currently Insured	4.9	0.4	0.4	--	$0.3
Currently Uninsured	20.0	1.9	1.8	1.8	$1.3
Total	**24.9**	**2.3**	**2.2**	**1.8**	**$1.6**
25 or Fewer Workers					
25 Percent Voucher					
Currently Insured	7.8	0.5	0.5	--	$0.2
Currently Uninsured	24.4	1.7	1.6	1.6	$0.8
Total	**32.2**	**2.2**	**2.1**	**1.6**	**$1.0**
40 Percent Voucher					
Currently Insured	7.8	0.8	0.8	--	$0.6
Currently Uninsured	24.4	2.5	2.4	2.4	$1.7
Total	**32.2**	**3.3**	**3.2**	**2.4**	**$2.3**

a/ Qualifying employers must have an average per-worker payroll below the statewide average for small firms.

Source: Lewin Group estimates using the South Dakota version of the Health Benefits Simulation Model (HBSM).

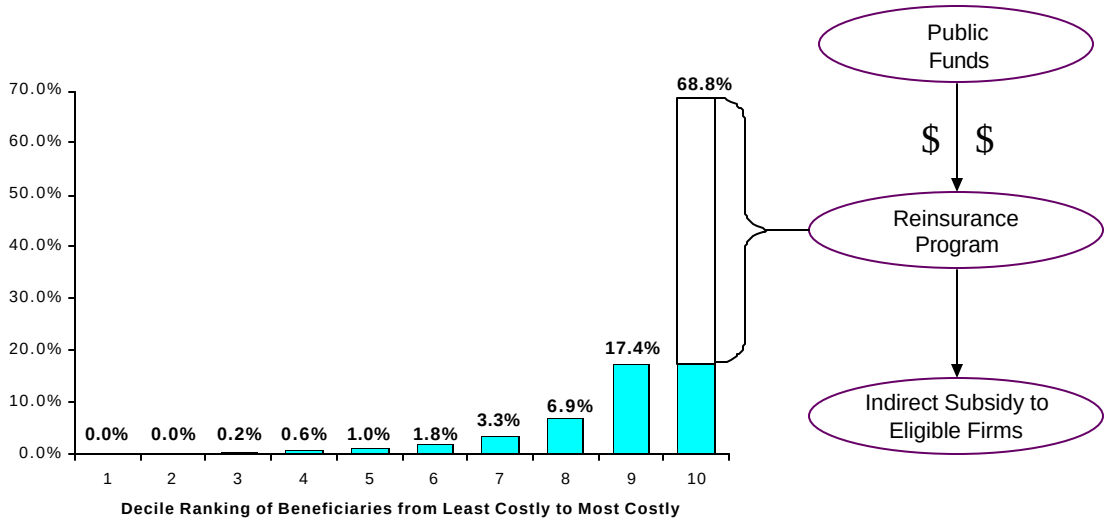
E. Option 5: Create Low-cost Health Insurance Coverage Options

The state could also expand coverage by subsidizing the cost of a low-cost health insurance product for employers who currently do not provide coverage. In this analysis, Lewin examined the potential impact of creating a program in South Dakota modeled on the "Healthy New York" program enacted in New York State in 2001. This program permits lower income individuals and employers with lower-wage workers to purchase a private health plan that does not include mandated benefits. The state also effectively subsidizes premiums for eligible employers and individuals in these plans through a modified reinsurance system.

The state subsidy is provided through a reinsurance mechanism that pays a substantial percentage of health benefits costs for high-cost cases among the eligible individuals and employers who purchase such a policy. As shown in ***Figure 6***, about 70 percent of all costs under a typical health plan are associated with just 10 percent of the covered population. This program subsidizes the cost of coverage for many of these high-cost cases, resulting in lower premiums. Under the Healthy New York program, the state reinsurance program pays 90 percent of costs in excess of $30,000 for each person covered under these plans up to a

maximum covered amount of $100,000 per member. The cost of this reinsurance is paid through trust funds established for this purpose using New York tobacco settlement receipts.[41]

Figure 6
Subsidized Insurance for Small Groups Through State-funded Reinsurance



Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

In New York, premiums under the program will be reduced by an estimated 15 to 20 percent. The elimination of mandated benefits accounts for half of this decrease while the reinsurance subsidy causes the other half. This reduction in costs is designed to increase the number of employers and individuals with insurance. The program currently has about 3,000 members. Enrollment is expected to grow as small employers and low-income individuals learn of their eligibility.

In this analysis, Lewin estimated the impact of adopting a similar program in South Dakota using the eligibility criteria established in the Healthy New York program. Self-employed people and the other individuals would be eligible if they have been uninsured for 12 or more months and their income is less than 250 percent of the FPL. Eligible employers would meet the following criteria:

- Firms with 50 or fewer workers;
- Have not offered coverage in 12 or more months;
- Less than 30 percent of employees are earning over $30,000; and
- The employer pays half of the premium.

[41] Katherine Swartz, *Healthy New York: Making Insurance More Affordable for Low-Income Workers*, New York: The Commonwealth Fund, November 2001.

This program would have less of an impact on premiums in South Dakota than it does in New York because South Dakota has fewer mandated benefits. Thus, the reinsurance subsidy would have the most significant impact on premiums in South Dakota. For purposes of developing estimates for South Dakota, Lewin assumed that the program would reduce premiums for enrolled firms and individuals by about 12 percent.

Lewin estimated that in response to these premium reductions, about 6,400 people would take coverage under these health plans. This includes both individuals and people in firms that purchase this subsidized coverage ***(Figure 8).*** Of these, nearly all would have been uninsured. The total cost to the state of the reinsurance program would be $1.7 million.

Figure 8
Developing a Low-cost Benefits Package for South Dakota a/

Eligibility	Number Enrolled (in thousands)	Newly Insured (in thousands)	State Cost (in thousands)
Non-insuring firms with 25 or Fewer Workers Only	3.6	3.0	$1.0
Uninsured Individuals Below 250 percent of FPL	2.9	2.9	$0.8
Both Non-insuring Small Firms and Uninsured Individuals	6.4	5.7	$1.7

a/ Numbers do not add to totals due to overlapping eligibility.

Source: Lewin Group estimates using the South Dakota version of the Health Benefits Simulation Model (HBSM).

F. Option Six: Expanding Direct Health Services

The final option models an expansion of direct services through physician offices, hospital outpatient departments, and community health centers as a means of improving access to health services in the state. The option would increase the availability of free or subsidized health care for one population group about whom South Dakota policymakers are especially concerned: uninsured adults 55 to 64 years of age. Although only 8.3 percent[42] of South Dakota's population is in the 55 to 64 year-old category, the probability of this age group being uninsured is higher than for other adult age groups. Across the United States, adults aged 55 to 64 are the fastest growing group of uninsured persons.[43]

For this late middle-aged group, health insurance is a particularly pressing issue for many reasons. First, those who have been laid off or taken early retirement have few viable insurance options since they remain ineligible for Medicare and face difficulty in securing affordable individual coverage. Second, this age group tends to have a higher prevalence of chronic conditions that often result in denials and limitations in coverage available through the individual market. In addition, researchers have found this age group more likely to experience a major

[42] US Bureau of the Census, Census 2000 Summary File.
[43] P.F Short, D.G. Shea, and M.P. Powell, A *Workable Solution for the Pre-Medicare Population*, The Commonwealth Fund, December 2000.

decline in overall health when they have no health insurance. All of these considerations necessitate an expansion of affordable coverage and care for 55 to 64 year olds.

As a result, the late middle-aged group tends to purchase individual private insurance more often than other age groups. Individual insurance, however, is typically very costly. Insurers can charge higher premiums to older Americans because they file more claims. Since administrative costs can not be spread over a group of policyholders, insurers assert that only individuals at high risk of needing health care will purchase policies.[44] As a result, 71 percent of adults age 55 to 64 find it very difficult or impossible to buy affordable coverage on the individual market.[45]

The older subset of the uninsured population face significant health concerns. In general, medical expenditures for 55 to 64 year-olds are more than twice the average for the 35 to 44 age group. Additionally, the incidence of work-related disabilities increases with age.[46] Uninsured adults are less likely to obtain necessary preventive health care services, resulting in poorer health outcomes compared to insured persons. Approximately 40 percent of uninsured adults skipped a recommended medical test or treatment according to a recent Kaiser Commission on Medicaid and the Uninsured.[47] The Commission also found that uninsured adults were 30 percent less likely than insured adults to have had a check-up in the past year.[48] The majority of uninsured adults lack a regular source of care, which has been shown to be a crucial factor associated with the receipt of preventive services. Finally, continually uninsured adults in their late middle ages experienced a sharper overall decline in health between 1992 and 1996 compared to continuously insured persons. Furthermore, they are more likely to develop difficulties walking or climbing stairs when compared with continuously insured adults.

Even though the proportion of uninsured 55-64 year olds is 10.7 percent and lower than other age groups in South Dakota, the consequences of uninsurance among older adults and the findings from South Dakota focus groups provide a compelling argument for expanding either affordable coverage or direct health services for the late middle-aged population. Pursuing this option would allow for greater health care service use, improved health awareness and outcomes, and would ease the financial burden that the uninsured experience. For uninsured older adults, it would encourage them to seek timely care for treatable problems, thus preventing costly and catastrophic circumstances in the future. Ultimately, expanding affordable health care potentially reduces the burden of illness, increases productivity, and promotes the overall wellbeing of the older adult population.

The direct care model should provide uninsured people with basic services. This service delivery approach of community-based care builds on the local commitment of specific health care organizations, their physicians, and the community, to assure access to health services to

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[44] M.V.Pauly, and A.M.Percy, "Cost and Performance: A Comparison of the Individual and Group Health Insurance Markets," *Journal of Health and Politics, Policy & Law* 25, February 2000.

[45] L. Duchon, and C. Schoen. "Experiences of Working-Age Adults in the Individual Insurance Market," *Issue Brief* New York: The Commonwealth Fund, December 2001.

[46] Short, Shea, and Powell.

[47] Henry J. Kaiser Family Foundation, "The Uninsured and Their Access to Healthcare," *Fact Sheet,* January 2001.

[48] *Ibid.*

everyone. The direct care model is best exemplified in the "free clinics," and Federally Qualified Health Centers (FQHCs), that provide care on a sliding fee scale.

The model emphasizes primary and preventive care and provides assistance for accessing to additional care such as specialty care or pharmacy services. In some examples of this approach, patients are integrated into on-going primary care and treatment systems. In other cases, the free clinic sites provide services. At FQHCs, comprehensive primary care is provided on a sliding fee scale basis to those without insurance.

This is not a formal "insurance" program, but providers agree to see patients based on local criteria and in free clinics, and have the right to refuse to provide services. There is no "out of area" coverage except as defined by referral arrangements with tertiary care centers. The "direct care model" does not replace existing insurance programs.

The purpose of this program is to expand the availability of free or subsidized health care for needy individuals who continue to be uninsured. Uninsured older adults who present themselves at hospitals would be permitted to obtain services from participating physicians during regular business hours in the physician's office. Participants would be required to pay for a portion of the services on a sliding scale with income for people below 300 percent of the FPL.

There would be a need to communicate to the older uninsured population the availability of a Direct Care Program. There could be an office that the uninsured could call or visit to apply for the program. Other suggestions included application by telephone or mail. These other "entry points" into the program may be necessary if hospital staff do not have the time to properly screen individuals, process applications, and distribute information on the program.

There is also a question of whether it is feasible to assume that doctors would participate in such a plan given the shortage of medical professionals in most South Dakota counties. The state must consider how the doctors would get paid for their services, what the reimbursement rates would be, and how doctors could afford to treat people if they were not being fully paid for their services.

At this point, no costs have been estimated for this program. Unlike program entitlement expansion alternatives, a direct service expansion option would be implemented within specified resource constraints without respect to service needs. As South Dakota continues to build upon the work begun through the SPG initiative, one important task will be to inventory safety net providers throughout the state in order to pro-actively develop more and improved health care access points. President Bush's FY 2003 budget proposals to expand community health center sites and to strengthen the National Health Service Corps facilitate important access to care initiatives that could develop in South Dakota in the years ahead.

SECTION V: CONSENSUS BUILDING STRATEGIES

At the onset of the South Dakota SPG project, the Secretary of Health contacted the Governor's Office and the Secretaries for the Departments of Social Services, Commerce and Regulation, and Human Services to discuss the grant announcement. Through this exploration, the decision to apply for the HRSA grant was made, more than two years ago. State officials believed that the grant would provide important resources for studying the uninsured in the state and South Dakota's health insurance market. (The last survey of the state's uninsured population was conducted in 1991.) As the outlook for federal funding approval appeared favorable, the commitment of state resources necessary for preparing the HRSA application was approved.

To obtain broad support for the SPG project, State agency staff developed an overview and description of the project and distributed it to a wide range of stakeholders. Stakeholders were identified by senior State officials who recognized the importance of specific organizations as constituents and the value of diversity in representing the perspectives of South Dakotans. Through this outreach effort, the state received letters of support from the following organizations and individuals:

- South Dakota Retailers Association
- South Dakota Farmers Union
- South Dakota Farm Bureau
- South Dakota Association of Healthcare Organizations
- Aberdeen Area Tribal Chairmen's Health Board
- Aberdeen Area Indian Health Services
- South Dakota Legislative Research Council
- South Dakota Association of County Commissioners
- South Dakota State Medical Association
- South Dakota Council of Mental Health Centers
- The state's largest insurance carrier
- Two large HMOs in the state
- The State's Legislative Senate House Chairs for their respective Health and Human Service Committees.

The governance structure that was established to lead the South Dakota SPG effort was an Interagency Work Group comprised of staff from the following state agencies: Department of Health, Department of Social Services, Department of Commerce and Regulation, and Department of Human Services. State agencies were selected based on their ongoing regulatory and programmatic responsibilities for health care delivery, insurance market oversight, and Medicaid coverage in the state. While the Governor appointed the Department of Health as the lead agency for the SPG project, each agency made valuable contributions to the HRSA grant application and to the entire project.

The Interagency Work Group collaborated with each other, monitoring the SPG project's progress in completing designated tasks, and providing technical input to all major decisions concerning the grant. Each Work Group member was responsible for keeping the Secretaries of the various State agencies informed of SPG project developments and for apprising other Work Group members of issues that State agency leaders were concerned about. Work Group members were also designated as public liaisons to address questions and information requests from stakeholders and the general public. Legislative requests from stakeholders about the SPG project were responded to by Department Secretaries and the Governor's Office staff.

Based on a written agreement, The Lewin Group was charged with completing the data collection, data analysis, analysis of policy options, and drafting the final report to HRSA. The Interagency Work Group had the responsibility of guiding and monitoring Lewin's progress and approving deliverables. The Work Group provided ongoing technical guidance to Lewin during the SPG project. The Work Group and Lewin realized this goal primarily through weekly and detailed conference calls. As a decision making and governance entity, the Interagency Work Group effectively listened to one another and discussed and resolved issues. Work Group members had long-standing professional relationships with each other.

Public input was essential to the SPG process in South Dakota. Quantitative data were obtained through reaching out to employers and uninsured individuals via telephone surveys. Indeed, with South Dakota's small population, the project team recognized as the sampling framework was designed that the theoretical possibility existed for all household telephone numbers in the state to be dialed before the project was over. Many residents and employers of South Dakota directly called elected or appointed State officials to ascertain the legitimacy of the surveys and seek more information about the project. Qualitative data were obtained through focus groups and structured interviews.

In addition to the above, the South Dakota Department of Health submitted a statewide press release to the newspapers, radio stations, and television stations throughout the state after receiving the SPG Award Notice from HRSA. Additionally, during the data collection phase of the project, the DOH listed all the activities of the South Dakota SPG project on their web site. This was to insure respondents of the phone surveys, focus group interviewees, and stakeholder interviewees that the data collection activities occurred under State auspices. On both the press release and web site posting, contact information for DOH staff was also listed.

The SPG planning process has raised public awareness of health insurance in general and the uninsured in particular. Due to the short time frames involved, the project is expected to have a greater impact on South Dakota's policy environment during its second year. In two respects, the SPG planning process has advanced the potential for expanding affordable health coverage for state residents. The first year of the SPG grant resulted in new and up-to-date information about the characteristics of the uninsured in South Dakota. This information challenged existing assumptions about the composition of the uninsured population in the state. Survey data revealed the uninsured's attachment to the workforce and the consequences they experience as a result of having no health coverage. In addition, at the time the SPG grant application was made, no formal policy options had either been designed or considered to address the problem of the uninsured in the state. The SPG grant has facilitated the development of policy options that may be refined and possibly considered in the future.

No policy change can occur in South Dakota without support and involvement of key members of the Legislature. The timing of the 2002 Legislative Session (January-March) precluded State agency staff from providing information and building an awareness of alternatives to expand affordable health coverage in the state during this phase of the SPG project. It is anticipated that data and reports generated from the surveys and focus groups conducted in 2001 will be made available to Legislative members and staff in the months ahead.

In the second year of the SPG program, the Governor has indicated he will issue an Executive Order establishing a committee made up of principal stakeholders to discuss findings, review the presented options and determine what corrective actions are within the scope and ability of the state to respond. This committee is expected to meet periodically beginning in May, 2002 and will issue preliminary findings by fall. At a minimum, committee membership includes health providers, representatives of the health insurance industry, consumer advocates, employers and key policymakers.

In 2002, South Dakota, like many other states, faces a budget deficit as a result of a slumping national and state economy. Leaders of the State are currently addressing budget shortfall issues and examining the way services are provided. It is doubtful whether the State resources will ever exist to expand access to health insurance for all residents. Should the economy recover, it is possible that some policy alternatives could be enacted over the next three to five years. The feasibility of enacting some coverage programs in South Dakota would be enhanced if the federal government increased its share of funding in support of health coverage expansions.

SECTION VI: LESSONS LEARNED AND RECOMMENDATIONS TO STATES

A. Importance of State-Specific Data

State-specific data was essential to the SPG project's decision-making process and formulation of policy alternatives in South Dakota. Due to the expense of collecting state-specific data, past access efforts in South Dakota had been conducted without the benefit of extensive new data gathering and analysis. SPG funds were used to identify the characteristics of the uninsured in the state and the consequences individuals experience as a result of being uninsured. SPG funds enabled staff to generate detailed qualitative information on the experiences and perceptions of the un- and under-insured in South Dakota. Finally, SPG funds provided information, apparently for the first time, about employers in the state, the coverage that they offer, and the nature of the barriers to expanding employer-based coverage.

The opportunity to develop state surveys in South Dakota was important, given the state's unique characteristics and small population base. This process revealed geographic differences on many important dimensions. The lower rates of employer-based health benefits in the western half of the state, which is largely frontier and contains relatively large Indian reservations, led to the consideration of the development of private insurance subsidies as a policy option and to recommend federal funding improvements in the Indian Health Service. Since the vast majority of the state's population is either white or Native American (89.9 percent and 8.3 percent of the population, respectively), project staff determined that measurements on health disparities among ethnic subgroups would prove unreliable. Yet, the state-specific survey of the uninsured did provide a relatively low-cost opportunity to understand the extent of coverage among the *insured* population of South Dakota through the use of an abbreviated questionnaire. The information generated from the "screen-outs" will be used to address many health policy questions this year.

The qualitative research that the project team conducted included focus groups and structured interviews (described elsewhere in this report). The team captured and quoted the views of the focus group participants, giving a personal voice to individuals often overlooked as important health system stakeholders. Summaries of focus group member perspectives and experiences are valuable as future educational material for elected officials and advocacy groups who will be asked to engage in future policy development regarding the uninsured. Focus group findings have been particularly useful this year as an "early warning" mechanism, alerting Interagency Work Group members to the significant distress experienced by many state residents as a result of an escalation of health insurance firms exiting from the state's individual market.

B. Effectiveness of Data Collection Activities

Not enough time has passed to conclusively determine which data collection activities have been most valuable to the state. No particular data collection activity stands out as the most effective research strategy at this time. The surveys and focus groups were designed to complement each other in terms of the information developed, while building upon other areas of research. We believe that the research approach undertaken as part of South Dakota's SPG grant achieved state policymaking objectives and provided a firm foundation for moving forward with policy options.

C. Data Collection Proposed but Not Carried Out

Unlike the experiences of some other grantees, South Dakota staff conducted and completed all data collection activities within the specified and tight timeframe of the SPG project as originally proposed.

D. Strategies to Improve Data Collection

Many different strategies were adopted to improve both quantitative and qualitative data collection. For the state's telephone survey of the uninsured, a sampling frame was designed that assured an increase in the probability of rural and Native American respondents compared to strict population-based sampling (e.g. select every n^{th} household in county). Although Baselice and Associates Inc. (the firm that conducted the telephone survey) prepared to conduct the telephone survey in Spanish to capture immigrant respondents, this strategy proved unnecessary in South Dakota, given the state's population demographics. To reach the widest array of households in the telephone survey of the uninsured, Baselice generated telephone numbers from published sources and random digit dialing (RDD).

The project team adopted creative strategies to maximize a high show rate for the focus groups. In some unpopulated areas, American Public Opinion (the firm that managed the logistical details of focus group recruitment) hired a van to pick up recruited individuals and transport them to the focus group location. The project team was flexible regarding the time focus group sessions were held, varying sessions according to the perceived time constraints unique to each group. For example, one of the sessions was held in the morning so it would not interfere with the farmers' work day and scheduled high school Homecoming activities. Focus groups among Native Americans took place in locations that were well-known and comfortable for participants. Indeed, our efforts to help make focus group participants feel comfortable led one tribal leader to observe how open individuals seemed to be in expressing themselves to outsiders. A final strategy adopted to maximize focus group participation was a modest cash payment for each member.

Collecting data on the refugee population was originally a goal of the focus groups. However, the project team discovered early in the project that this group primarily lives in one area (Sioux Falls) and that the refugees are difficult to contact. To obtain information about this population, Lewin conducted a stakeholder interview with an organization that provides refugee advocacy services, Lutheran Social Services.

E. Need for Additional Data Activities

One outcome of the SPG project in South Dakota was the generation of additional policy questions that would call for new research in some areas. Research and data would be especially useful in the following areas:

- Analysis of attitudes of adults who are uninsured for long periods of time to understand why they do not avail themselves of current private and public coverage options.

- A study of uninsured or under-insured older adults (55-64 years) to determine the health status effects of this condition, treatment patterns for chronic conditions, and finally, preventable health system costs.

- A study of companies in the state that provide health insurance to those in the individual and small group markets to ascertain their compliance with state underwriting and coverage regulations.

- Market research to test consumer willingness to pay for a *specified set* of health benefits.

- The development of practical measures of "underinsurance" that can be used by policymakers and advocates to assess the well-being of state residents, as related to their health coverage.

- An analysis of the unique health care delivery system in the state (e.g. rural, under-served combined with vast Indian reservations) to understand residents' patterns of health care, geographic access, and opportunities to facilitate overall quality improvements.

During the past seven months the project team has become aware of a lack of information concerning adequacy of health benefit packages. What seemed to be a surprisingly high number of focus group participants reported that although a family member might be insured, his/her coverage was catastrophic, often with a $5,000 deductible. There is little information available as to the most common health benefit packages available within the state and carrier policies being written in the individual market. Such data could help the design of affordable benefit packages that would be attractive to South Dakotans.

F. Organizational Lessons Learned

Many operational lessons were learned during the course of the South Dakota SPG program. The first operational lesson was the value of establishing an interagency group of experienced state officials with a professional interest in the subject of the uninsured. The commitment exhibited during the SPG project, as well as the technical expertise shared by Work Group members, resulted in quality products that may be used by several agencies in the months ahead. Interagency staff collaboration improved the utility of data collection efforts and the interpretation of research results. This staff collaboration helps to assure that information and perspectives gained from the SPG project will provide a state policy foundation from which improved programs can be constructed in the future, even after some elected officials (such as Governor Janklow) leave office at the end of the year.

Another operational lesson was the importance of partnerning with contractors who have experience in designing and conducting surveys, leading focus groups and analyzing policy options. The use of modeling simulations can allow states to compare magnitudes of effects, such as increases in coverage rates and costs to the state of increased coverage, across an array of policy options. Modeling techniques can provide defensible information to supplement political information available to public and private policymakers. The project also appreciated the value of partnering with consultants who were flexible in their approach, as the state's policy environment evolved.

The most significant operational lesson learned is that it is surprisingly difficult to foster comprehensive state reforms that can expand affordable health coverage to all citizens. These reforms are difficult to enact in the absence of supportive federal policy and during times of severe fiscal constraints. When such a high percent of the state's population already had health insurance, it is difficult to mobilize elected leaders to initiate changes in the status quo. Finally, as in other states, there exist ideological barriers to addressing the problems of uninsurance. Despite information generated by this project, many South Dakotans have strong views on the value of self-sufficiency, skepticism about government intervention, and a reluctance for the state to assume financial responsibility for improving access to affordable coverage among Native Americans given federal treaty commitments.

Given the short time frame of the SPG project, it is too early to tell whether changes in the structure of health care programs will be proposed, along with methods for their coordination, as a result of the HRSA planning effort.

G. Key Lessons Learned About Insurance and the Employer Community

It is still too early to determine what lessons were learned about how to effectively work with the employer community to expand affordable health coverage. During its first year, the project emphasized data collection, limiting direct contact primarily to the Employer Survey, certain focus groups and stakeholder interviews. During the second year of the project, the employer community will be represented on the Governor's committee. This phase will provide more feedback since it involves consensus building and the formulation of an implementation strategy.

One of the large insurers in the state has expressed interest in receiving information from the surveys about characteristics of the uninsured. The insurer is considering developing a catastrophic health insurance product for the uninsured and recognizes the importance of assessing the potential demand for such an option.

H. Key Recommendations for States

The key recommendation South Dakota offers to other states considering a planning effort, such as the SPG program, is to recognize the long time that passes between data collection and potential implementation of policy options to expand health coverage. Furthermore, collecting data and designing a plan to expand health coverage are only a few of the many steps that state officials must undertake in the policy process. Implementation of any expansion effort requires a careful assessment of the economic and political feasibility of specific alternatives as well as ongoing leadership in this effort. Also required is an understanding of trade offs: if "new" state money is not allocated to health insurance expansions then from what agency's budget are necessary funds allocated?

There are several steps that states might consider in their policy planning process to "speed-up" their activities, given HRSA's compressed time frames for the SPG projects. They include:

- Schedule data collection (such as surveys and focus groups) in parallel to the identification and analysis of policy options. State-specific information about the

uninsured is most useful to the policy analysis process after considering a framework that identifies a realistic span of options.

- Reduce time spent on "gearing-up" early in the SPG project. If possible, consider including consultants while writing the SPG grant application (to eliminate the need for bidding); and develop state Requests for Proposals before receiving the federal grant award.

- Establish clear project work plans and monthly progress reports.

Finally, states need to be prepared to devote significant resources to educating elected leaders, health system stakeholders, and the general public about the dimensions of the uninsured problem and realistic alternatives for addressing it.

I. Changing State Policy Environment

Since the time South Dakota submitted its HRSA grant proposal, several significant changes occurred in the State's policy environment. First, there is a state budget crunch. State tax revenues have grown more slowly than expected as a result of the U.S. and South Dakota economic recessions. State sales tax revenues grew by only 1.66 percent over the latest 12 month period, compared to a six fiscal year historical average of 5.9 percent.[49] The budget shortfall of $18.1 million in the current year is projected to grow to $36.3 million in FY 2003.[50] Part of the deficit results from a projected increase of $19.4 million to fund the State's Medicaid program in FY 2003. To balance the state's budget in FY2002, transfers are being made from the Reserve Fund and Property Tax Reduction Fund. To balance the FY2003 budget, transfers will be made only from the Property Tax Reduction Fund. The State Legislature was extremely reluctant to consider new or expanded programs during this 2002 session. The Legislature did, however, keep most existing programs in place by allocating reserve funds rather than by cutting vital programs or increasing taxes.

Second, as a result of the unforeseen events of September 11th, Governor Janklow significantly increased efforts to upgrade the state's terrorism and bioterrorism preparedness. Many State officials were redeployed to address priority issues of airport and aircraft security, community infrastructure security, mail handling, chemical security, and bioterrorism.

Third, with new and unexpected budget constraints, State officials are understandably wary about looking to the federal government as a partner in the efforts to increase affordable health coverage in the state.

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[49] South Dakota Bureau of Finance and Management, *Economic Forecast and Revenue Report*, February 2002.
[50] *ibid*

J. Change in Project Goals

The State of South Dakota initiated no change in the SPG project goals during the grant period.

K. Next Steps in Efforts to Expand Health Coverage

Due to the necessity of having to produce a final report at the end of the first twelve-month period, it was always believed that staff would emphasize data collection and analysis for the first year. A possible second year would be devoted to a more detailed analysis of policy options coupled with consensus building.

This now appears to be the case since the state has applied for and received federal authority to extend the SPG program for 12 additional months and Governor Janklow has indicated his intention to issue an Executive Order establishing a committee. This blue ribbon committee will be made up of a number of stakeholders, including representatives of the health insurance industry, consumer advocates, employers, health providers, and policymakers.

There have been no discussions concerning longer-range activities and much of this will depend upon the new Governor taking office in 2003. At this point, there is some desire to at least minimally maintain a point of contact for the SPG program and to apply the data which have been collected through this effort.

SECTION VII: RECOMMENDATIONS TO THE FEDERAL GOVERNMENT

One of the objectives of the SPG program is to provide recommendations to the federal government about what it can do to help increase access to health insurance coverage throughout the United States. The federal and state policy environments have changed dramatically this year due to the September 11 tragedy and a national economic recession. If the federal government expects to maintain recent coverage expansions (such as SCHIP), it must do more than offer regulatory flexibility this budget year and provide real financial assistance to states, particularly with respect to their Medicaid budget shortfalls. Altered federal priorities, a drop in the federal budget surplus, and steep drops in state tax revenue have made states wary of embarking upon new coverage expansions for the uninsured when circumstances threaten existing programs.

HRSA's guidance for Section Seven of this HRSA report calls for South Dakota's conclusions about what, if any, coverage options selected by South Dakota would require federal waiver authority or other changes in federal law. None of the options described in Section Four of this report *require* federal waivers to enact. At this point, the State of South Dakota has not selected any particular coverage option for implementation. The policy option review and selection process should continue for the remainder of this calendar year (2002) among State officials. It is possible that once policy options are fine-tuned, the need for federal waiver authority may be considered.

It should be noted that Medicaid waiver authority, such as the Health Insurance Flexibility and Accountability (HIFA) 1115 demonstration proposal adopted in 2001, might have a limited impact in a state such as South Dakota. This is because there is little "fat" to cut out of the Medicaid supported delivery system that could be re-allocated to coverage expansions in order to achieve federal budget neutrality specifications. In states with virtually no managed care penetration (approximately six percent HMO penetration rate in South Dakota) or excess provider capacity (nearly 70 percent of counties in South Dakota are medically underserved areas), it is difficult to imagine how Medicaid service delivery and benefits could be restructured in ways to generate sufficient savings that could be applied to new program expansions.

The South Dakota SPG project recognizes the importance of federal action in one particular area to support the State's efforts to provide coverage for the uninsured. In addition to the reforms the state is considering, the federal government should offer (federal) tax credits for purchasing health insurance coverage. The proposals currently before Congress[51] vary in the dollar amount of tax credits that could be available, the income levels specified to qualify, and the mechanism that could trigger eligibility (for example, employment in firms that offer health insurance, limit to small firms only, purchase coverage in individual insurance market, etc.). Regardless of the approach taken, federal action could be particularly appealing for South Dakota residents, a state

[51] Such as the Relief, Equity, Access and Coverage for Health (REACH) proposal (S. 590) that would offer income-based tax credits of $1,000 for individuals and $2,500 for families without access to employer coverage and tax credits of up to $400 for individuals and $1,000 for families eligible for employer coverage.

with no individual or corporate income tax and a median household income that is nearly 20 percent lower than the U.S. as a whole.[52]

In addition to possible waiver authority, the federal government can provide resources and support in many areas to facilitate efforts to identify those with inadequate coverage in states, such as South Dakota. These include:

- Noticeable progress has been made at the federal level to improve estimates of the uninsured. For example, recent CPS expansions nearly doubled the number of South Dakota households in the CPS March Supplement (to 1,640) and are expected to decrease the standard errors of the estimates by 27 percent.[53] It is important that federal efforts to increase state sample sizes in the Current Population Survey March Supplement and Medical Expenditure Panel Survey and to assess the reliability of survey questions continue even as federal budgets are curtailed. Such efforts will help to improve the stability of year-to-year estimates and increase the utility of the CPS for state monitoring purposes over time.

- State-level information on the uninsured, employment and income, and health care utilization should be available to state officials on a timely basis and in formats that can be used to meet particular state analytic needs.

In addition to surveys of the uninsured, there exist many other areas of research that the federal government could undertake to assist states in meeting the coverage needs of their residents.

- During the course of the SPG project, many South Dakota state officials have become increasingly concerned about state residents who are reportedly *underinsured*. Although individuals may have health insurance, their coverage is often limited. Many focus group participants reported they had policies that only covered work-related accidents or have plan deductibles of $5,000 or more. The Interagency Work Group recommends that the federal government initiate research efforts to define the meaning of "underinsurance," measure the affordability of health insurance, identify the prevalence of underinsurance by economic sector, and capture consumer perspectives in this effort. As we believe the experience of *underinsurance* varies by geographical location, the federal government should engage state officials in research collaboration on this topic.

- The difficulty of inducing uninsured individuals to enroll in available private or public coverage has frustrated many state officials in South Dakota and elsewhere. The federal government should sponsor research to understand why individuals do not sign up for available private or public coverage. While limited income and welfare stigma play a role, focus groups on the uninsured demonstrated that other important reasons cause this consumer behavior, as well.

- Access to quality health care in frontier areas (less than seven people/square mile) is a growing concern among uninsured and insured residents of the state. Health insurance is of

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[52] U.S. Census Bureau. American Fact Finder, Profile of Selected Economic Characteristics, 2000 (QT-03).

[53] State Health Access Data Assistance Center (SHADAC). "Impact of Changes to the Current Population Survey (CPS) on State Health Insurance Coverage Estimation," *Issue Brief,* March 2001.

limited value in facilitating timely access to health services when needed medical care is simply unavailable within a 100 mile radius, for example. The federal government should study frontier health care practice models and identify new and creative solutions to the difficult issue of diminished availability of services and access to care.

- The federal government should adequately fund the Indian Health Service (IHS) to the extent that this health system meets federal treaty commitments and provides quality health and medical services to Native Americans within coverage areas. This recommendation is important to both tribal and State officials who recognize the severe and unmet health care needs of a rapidly growing and highly impoverished sector of the state's population. (Native Americans made up 8.3 percent of the state's population in 2000.) The infant mortality rate of Native Americans in South Dakota rivals that of many developing countries (exceeding 17 percent for much of the 1990s, dropping to 11.3 percent in 2000).[54] The years of potential life lost among the Aberdeen tribes (many of whom are located in South Dakota) was nearly 2.5 times the U.S. rate nearly a decade ago.[55] Coverage and service problems identified through the SPG project's focus groups and interviews include:

  - cumbersome and oftentimes long federal process to establish individual's eligibility for Indian Health Services;
  - provider shortages and limited facilities and service capabilities in many areas;
  - consumer dissatisfaction with IHS health service quality and scope in many areas;
  - consumer and provider dissatisfaction with IHS contract health services requirements, typically necessitating long travel and waiting/access delays;
  - federal resources that are grossly insufficient to meet populations health care needs;
  - cumbersome intersection among IHS, Medicare, and other payers' policies and regulations that inhibit timely delivery of care and payment for care received.

With the state's low population (754,844 persons in 2000) and vast land area (9.9 persons/square mile in 2000[56]), it is likely (according to several diverse stakeholders interviewed) that federal leadership in this area could facilitate health care and coverage improvements for South Dakota residents, as a whole, and not just the Native American population, and still conserve public funds.

One final recommendation that the SPG project offers is that federal Employee Retirement Income Security Act of 1974 (ERISA) guidelines should be amended, particularly those related to federal preemption of state laws for self-funded plans. This would enable state governments to evenly and effectively modify their health insurance markets and incorporate all payers in any reform measures.

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[54] SD Department of Health, Data, Statistics, and Vital Records Unit. *South Dakota Vital Statistics and Health Status: 2000*, January 2002.

[55] U.S. Indian Health Services. *Regional Differences in Indian Health, 1998 – 1999.* http://www.ihs.gov/publicinfo/publications

[56] Compared to 79.6 persons/square mile for the U.S. as a whole, according to the Bureau of the Census.

The State Planning Grant process revealed the importance of continued *federal* leadership in solving the problem of the uninsured throughout the United States. In South Dakota, with nearly 92 percent of its residents having some degree of coverage, it is unrealistic to believe that this state (or any state) can induce the remaining uninsured population to enroll in private or public health coverage programs. Subsidy levels would have to be extremely generous and it is unlikely that the majority of insured residents would support allocating state funds to support such a subsidy program.